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Muslim women are defending secular constitution

LEBANON
Infrastructure quality reflects local communities' status

WEST AFRICA
What kind of opportunities tech hubs are providing

Poverty and disease

In German E+Z
Entwicklung und Zusammenarbeit.
Both language versions
at www.DandC.eu

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Title: TB patient in the Kolkata agglomeration.
Photo: picture-alliance/imageBROKER

FOCUS

Poverty and disease

Ebola – five years later

Sierra Leone was devastated by the Ebola outbreak from early 2014 to late 2015. Some lessons have been learned – especially in regard to community-based action. Whether the country is properly prepared for another major health crisis remains an open question nonetheless, warns civil-society activist Shecku Mansaray. **PAGE 21**

Professional services for all

Splitting up health care between government and private-sector institutions can prove counterproductive and certainly does not lead to everyone enjoying access to quality care, argues Andreas Wulf of medico international, the Frankfurt-based non-governmental organisation. As Hannah Hussey, a physician from South Africa points out in a short essay she co-authored with three of her colleagues, poverty and low vaccination rates are interrelated phenomena. More effective vaccination campaigns thus contribute to fighting poverty. Martin Rohacek, a doctor from Switzerland, elaborates how professional emergency care can be provided even in rural Tanzania. He set up such a facility at St. Francis Hospital in Ifakara. **PAGES 23, 25, 27**

Costly medication

Diabetes affects poor and rich people alike. The poor suffer in particular, however, especially in places where public health care is unreliable and important drugs are unaffordable. Zimbabwe is an example, journalist Jeffrey Moyo reports from Harare. **PAGE 29**

Make the world TB-free

In the past three decades, progress in the fight against tuberculosis (TB) has slowed down. Reasons include the emergence of drug-resistant strains and the HIV/AIDS crisis. To make the world TB-free, funding must increase dramatically, writes Roli Mahajan, a freelance journalist from India. **PAGE 30**

WASH your hands

Appropriate hygiene can prevent many infectious diseases. Accordingly, the acronym WASH (for water, sanitation and hygiene) has been a development buzzword for the past 20 years. Ella Naliponguit, who works for the government of the Philippines, told Linda Engel what a national school programme is achieving. **PAGE 32**

OUR VIEW

Systemic market failure

Poverty and poor health are closely interrelated. Poor people are more likely to suffer from illness and likely to suffer more. The reason is that their lives are tougher in general. Their diets are less healthy and they do harder physical work. All too often, moreover, they lack access to health care. On the other hand, sick people are more likely to fall into poverty because their capacity to earn money is reduced and they must cover high medical costs. On average, poor people's life expectancy is shorter – and as they do grow older, their probability of suffering from a chronic disease is particularly high.

For these reasons, the quality of a country's health-care system has a huge bearing on its prosperity. All rich nations have tightly woven networks of hospitals and clinics. Moreover, their legislation and public service providers ensure that the vast majority of their people have access to professional health care.

Things are different in developing countries and emerging markets where the kind of treatment a patient will get basically depends on purchasing power. Prosperous people turn to private practitioners and some even go abroad for better treatment. Most people, by contrast, have to cope with bottlenecks and various kinds of deprivation.

Markets do not function well in every sector. In health care, market failure is systemic. Many healthy people do not worry much so they prefer spending their money on things other than health insurance. Unless there is prudent regulation, far too many people thus remain unprotected. Those who suffer a serious illness, by contrast, are willing to pay almost any price to get better, but they do not really know what kind of therapy will actually help them. Prudent laws and competent oversight by government authorities must protect them from exploitation.

Market failure, moreover, is the reason why there is a lack of medications and vaccinations for neglected tropical diseases. They cause mass suffering, but developing pharmaceuticals for tackling them is not commercially attractive.

For these reasons, health care must not be left to market forces. Governments must act. A well performing health sector reduces considerable economic risks – to the benefit of household and private-sector companies. That is a precondition for a nation to prosper. There is no alternative if humankind is to fulfil the imperative of the Sustainable Development Goals (SDGs): "Leave no one behind!" For good reason, the Millennium Development Goals, the previous multilateral agenda, emphasised health issues even more.

Health care must be made as good as possible in developing countries and emerging markets. Funding and expertise will be needed, and international cooperation must contribute to progress.

Well performing health care, after all, is a global public good. The new corona virus (covid-19), which first emerged in China, is an example. When these lines were written, it was spreading surprisingly fast in Italy – so fast, indeed, that some municipalities had been cordoned off. News from Iran was similarly frightening. It is too early to tell what harm covid-19 will cause to people's health and national economies. It is obvious, however, that poor people and poor countries are set to be affected the most.

You'll find all contributions of our focus section plus related ones on our website – they'll be compiled in next month's briefing section.

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Debate

New confidence in judiciary

Malawi's Constitutional Court has annulled the presidential election of May 2019, arguing that the results were manipulated. Incumbent Peter Mutharika had been declared the winner last year. The judges' ruling against election fraud has boosted people's trust in them, writes Raphael Mweninguwe, a journalist. **PAGE 11**

Tribune

Muslima defending constitution

In India, a mass movement is opposing the national government's Hindu-supremacist agenda. Activists insist that the country's secular constitution, which prohibts faith-based discrimination, must be upheld. Muslim women are leaders. According to journalist Arfa Khanum Sherwani, the ruling party's poor showing in recent regional elections may indicate that it is losing its grip on the country. **PAGE 14**

Building digital nations

Tech hubs are now being established all over the world. They offer unprecedented opportunities – but also face specific challenges in developing countries. Ely Manel Faye, an entrepreneur from Senegal, assesses the West African scenario.
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Photos: Thoko Chikondi/picture-alliance/AP Photo; Makhija/picture-alliacne/NurPhoto

MACROECONOMICS

Dangerous climate

A recent publication shows that leading central bankers worry about the climate crisis. They argue that financial stability depends on climate stability. At the same time, German debt-relief campaigners warned that climate impacts are increasingly contributing to sovereign-debt problems around the world.

By Hans Dembowski

The Bank for International Settlements (BIS) is based in Basel and serves as something like an umbrella organisation of central banks. It does not normally make headlines and has a history of promoting orthodox economic theories. In a recent publication, on which it cooperated with the French central Bank, Banque de France (BdF), it calls for two paradigm changes.

The study is called "The green swan". As the authors elaborate, the term refers to what is called "black swan event" in economic theory. These events

- are unexpected and rare,
- have wide-ranging or even extreme impacts, and
- they can only be explained after the fact.

An economic crisis is likely to be severe if a black swan event triggers it, and policymakers will not know how to come to grips with it. "Green swan events", as defined in the BIS publication, are black swan events with environmental causes. The authors worry about global warming in particular, but they also point out that other issues, the erosion of biodiversity, for example, may trigger severe crises too.

Green swan events are more dangerous than conventional black swan events, according to the study. The reason is that economic policymaking cannot undo the environmental damage. Inflation can cause severe suffering in a country, but once the central bank and the finance ministry manage to halt it, a restart is possible. If, by contrast, the environmental foundations of an economy are broken, the central bank and the finance ministry cannot repair them.

The authors insist that green swan events have become so probable that central banks must prepare for them. To do so, they must adopt new methods for assessing risks. In the past, it was basically considered enough to compare current data with historical data in order to see whether a problem was building up that resembled a previous problem. In view of fast change, that approach no longer makes sense. The great challenge is to understand what new risks arise, how to assess them and what to do about them.

Adopting entirely new methods is the first paradigm change the study demands. The authors warn that central banks must act if they do not want to be overwhelmed. Food-price inflation may become severe, they argue, should harvests be destroyed by flooding, storms and drought. Problems may be compounded by harvests never returning to normal again. Moreover, climate disasters could erode people's wealth by destroying uninsured assets, reducing both their purchasing power and productive potential. On the other hand, insurance and reinsurance companies may prove unable to pay for all the damages that are insured. In such cases, systemically important financial-sector corporations may have to be bailed out.

The authors demand that central banks take into account what climate-related risks financial-sector companies are running. They want those companies to report to the public on these matters. Eco-risks should have a bearing on companies' access to capital. For example, those running high risks should have to pay higher interest rates.

On the other hand, the authors want distributional impacts to be assessed – both of global warming and of policy responses. The BIS publication warns that poor people and poor countries are affected worst. As policy implementation depends on broad public acceptance, it insists that disadvantaged parties must be compensated for hardship.

The study does not deal with carbon pricing. The authors state that it is necessary and has been discussed for decades, but policymakers have done too little to bring it about. Now, much more must happen. The expert team even suggests that governments should engage in deficit spending in order to boost climate-friendly technology

Locusts have multiplied because of unusually wet weather last year and are now causing serious damage in Kenya.

Photo: Curtis/picture-alliance/dpa

Hurricane Matthew over Haiti, Cuba and Jamaica in October 2016.

and build carbon-neutral infrastructure. The normally orthodox BIS now finds global warming more worrisome than government debt, and in view of currently low interest rates, they suggest that states have fiscal room for manoeuver.

This message fits the second paradigm shift the BIS experts demand. They want central banks to assume a new role in convening relevant actors and building alliances to promote effective climate action. They want central banks to become engaged at national and international levels. They insist, among other things, that rich nations must support adaptation and mitigation measures at least to the extent promised.

Quite obviously, the BIS and BdF deserve praise for spelling out that the climate crisis will have serious impacts on the world economy. Their authors express regret for research on the economic risks only having begun quite recently. To some extent, that is an admittance of guilt. That global warming is dangerous was spelled out clearly at the Earth Summit in Rio de Janeiro in 1992. Obviously, central-bank economists neglected the matter for quite a long time.

DEBT RELIEF FOR CLIMATE ACTION

According to erlassjahr.de, the German non-governmental advocacy group, many developing countries and emerging markets are once again struggling with worsening debt problems. Global warming is increasingly contributing to these problems.

For a recent publication, erlassjahr-authors assessed the debt situation of 154 developing countries and emerging markets. They found that 124 were critically indebted. Things are particularly bad in Bhutan, Mongolia, Sri Lanka, Djibouti, Cape Verde, Mozambique, Sudan, Argentina, El Salvador, Jamaica, Lebanon and Kyrgyzstan.

The report spells out clearly that the climate crisis is adding to the problems. According to erlassjahr.de, this is particularly true of small island states and the Sahel region. On the one hand, countries suffer shocks through extreme weather events, and they need humanitarian assistance when such disasters strike. Their domestic capacities are typically overwhelmed by massive storms, floods or droughts. On the other hand, incremental climatic change may erode an economy's productivity, especially if agriculture is its most important sector. Both the sudden catastrophe and the slow onset erosion of productivity, can undermine a country's capacity to service its international debt.

The authors argue that the current debt scenario differs from the one in the late 90s that ultimately led to multilateral debt relief after the turn of the millennium. This time, loans from the People's Republic of China and its financial institutions constitute a large share of the debt. Moreover, private-sector lenders play a greater role. The implication is that more parties are involved, and it will be more difficult to broker solutions. On the upside, the governments of established donor countries are now more prepared to deal with over-indebtedness in a more flexible manner than they were in the past.

There is, however, no coherent and systematic approach to managing over-indebtedness. According to erlassjahr.de this results in harmful uncertainty. The organisation has been pointing out for years that a predictable multilateral mechanism is needed. For good reason, it does not want any donor-dominated institution to play the leading role. Though the International Monetary Fund (IMF) has the necessary technical competence, it cannot serve as a fair arbiter because it is itself a lending institution.

This year's debt report includes proposals on how to link debt relief to climate action. For example, debt servicing could be suspended after a hurricane, with the national government being permitted to use that money for disaster relief. The authors quote Pope Francis, endorsing his view that donor nations have incurred an environmental debt in poor world regions. In their eyes, this should be considered when disadvantaged countries' debt issues or their infrastructure needs are being discussed. Erlassjahr.de is a faith-based organisation, and its recent debt report 2020, was published in cooperation with Misereor, a Catholic charity.

Erlassjahr.de admits that designing policies that take these things into account will prove technically difficult. Every country is special in its own particular way, so it is hard to define rules that fit all parties and every situation. The report spells out convincingly, however, that the problems are growing and that conclusive rules on over-indebtedness would help to tackle not only financial crises, but the over-arching environmental crisis as well. It appeals to Germany's Federal Government to:

- ensure that climate-induced disasters do not lead to debt crises,
- promote the establishment of a multilateral mechanism for debt relief and
- support related multilateral and regional initiatives.

LINKS

BIS – Bank for International Settlements, 2020: The green swan – Central banking and financial stability in the age of climate change.
https://www.bis.org/publ/othp31.pdf
Erlassjahr.de, 2020: Schuldenreport 2020 (so far only available in German. An English translation is being prepared and should be online on the erlassjahr.de/en website in April or May. The title will be: "Global Sovereign Debt Monitor 2020")
https://erlassjahr.de/wordpress/wp-content/uploads/2020/01/SR20-online-.pdf

Photo: Eumetsat/picture-alliance/dpa

DROUGHTS

The political causes of famine

A new book explores what makes people vulnerable to drought, and what makes them resilient. It shows that good governance can prevent famine. Robust drought-management plans must be based on the thorough anticipation of risks. And they must be designed well before a drought sets in.

By Floreana Miesen

Global warming is increasingly blamed for causing drought-induced famines. In fact, a trend of recent decades is that dry periods occur ever more often and have serious impacts on agriculture in the regions affected.

Not all problems can be attributed to the climate crisis, however. Michael Brüntrop of the German Development Institute (GDI) says: "The drought challenge is older than climate change." The underlying causes of famine must be better understood. He finds it disturbing that famines are recurring with an increasing frequency even though the world market and international food-supply chains mean that people are now generally less dependent on local yields than they were in the past.

A new book that Brüntrop co-edited explores the challenges of drought-induced famines. The book includes case studies from developing countries, spells out what makes people particularly vulnerable to droughts and identifies options for action. One message is that, in many countries, the political dimensions of drought and ensuing needs are not properly acknowledged even though comprehensive and coherent drought management can prevent famine.

It was launched at an event hosted by GDI and the Secretariat of the United Nations Convention to Combat Desertification (UNCCD) in Bonn in January. Daniel Tsegai of UNCCD, another co-editor, insists that risks and vulnerabilities must be systematically assessed long before a drought happens. He wants impacts to be anticipated and institutions to be prepared for the worst. Most countries claim they have a drought-management scheme, but often, these are only emergency plans, Tsegai warns. Failure is sometimes caused by a lack of funding, but structural issues are normally more crucial, with the importance of drought planning not being recognised.

Kenyan women fetching water from a dry river bed in the Machakos region: drought impacts are gender specific.

Photo: fm

The book includes chapters that explore the potential of satellite-supported early warning systems. This approach is especially relevant in conflict zones, where environmental ground data cannot be collected systematically, Tsegai points out. All too often, however, the wealth of information from satellite data remains useless, because it is not used to draft adequate strategies for preventing famines.

Mechanisms for building resilience are urgently needed, says Brüntrop. He suggests innovative drought-insurance regimes. Moreover, more stable and diversified incomes would reduce the dependency on local agricultural yields. This is especially important for women, who are most vulnerable in times of drought. Well-designed drought response must therefore be gender sensitive. The editors also want drought management to be improved continuously. Otherwise, droughts will continue to undermine livelihoods, erode people's trusts in institutions and reduce our collective chances to achieve sustainable development.

Drought management and adaptation is all about good governance, agrees Maryke van Staden of the global network ICLEI – Local Governments for Sustainability. All government officers must understand their roles and assume responsibility accordingly, she says. Local governments, for instance, should assess vulnerabilities and alert with higher-level government agencies. She emphasises the need to think holistically.

The film "The end of famine" documents the different dimensions of drought management in East Africa. Directed by Patrick Augenstein, it emphasises the political dimensions of drought-induced suffering. The movie was also shown in Bonn. It demonstrates that farmers are well advised to diversify the crops they cultivate, for example, and assesses the response routines of the World Food Programme. Augenstein's film points out that no famine has ever happened in a country with a fully functioning democracy – which proves that overpopulation is not a root cause of famine.

REFERENCES

Book: Mapedza, E., Tsegai, D., Brüntrup, M. and McLeman, R. (eds.), 2019: Drought challenges – Policy options for developing countries. Amsterdam: Elsevier Science.

Film: Augenstein, P.: The end of famine. ***https://www.youtube.com/watch?v=vgP9W9amAM8***

ANALYSIS

End colonial amnesia

The relationship between Germany and Africa is still marked by an unresolved colonial past. This state of affairs is analysed and criticised by a number of authors in a new collection of essays that was edited by D+C/E+Z contributor Henning Melber. The essays do not deal only with the colonial past; they also address contemporary issues such as green finance or gender relations.

By Sabine Balk

Henning Melber believes that coming to terms with the colonial past and acknowledging Germany's guilt are vital foundations for an Africa policy at eye level. He explained why at a recent presentation of his book in Frankfurt. However, he sees no signs any significant moves lay those foundations at present. On the contrary, Melber bemoans a "colonial amnesia". Germany has largely lost the historical memory of German injustices such as the genocide of the Ovaherero and Nama people in what is now Namibia. Too often, he says, colonialism is still glorified as a civilising mission. That narrative is keenly espoused by AfD, Germany's right-wing populist party.

Melber explains why "colonial amnesia" often prevails even in supposedly enlightened circles. "It seems that many have decided 'enough is enough'." By tackling the Nazis' genocide of European Jews, they think that Germans have done more than any other nation to face up to past crimes. Lots of people fail to realise, however, that the first German genocide occurred in Africa, and dealing with that would contribute to understanding the Holocaust.

Moreover, racism is quite common in Germany. In the book, civil-rights activists Tahir Della and Bebero Lehmann see a direct continuity between "colonial amnesia" and racist attitudes towards black people in Germany. Failure to come to terms with the past has shaped Germany's self-image as a nation of white people. The presence of black people in Germany is only insufficiently acknowledged. "Black people are still marginalised and become alienated in Germany today," the authors complain. Practically every black person in Germany is likely to have experienced racism, "not just in daily life, in the form of racist language and hostility, but institutionally". That happens in day-care centres, schools, the housing and job market.

Racism is equally evident in so-called racial profiling – the practice by police, security and immigration officials of targeting individuals as suspects on the basis of stereotypes. People are singled out not because of actual suspicious behaviour but because of the way they look and their ethnic, religious or national background. Many of those affected, for example, say they were targeted for no other reason by ticket inspectors on public transport. Della and Lehman condemn this as discrimination against black people – discrimination that they also see in the German state's handling of refugees from Africa.

Congo-born Boniface Mabanza Bambu, coordinator of the Christian service centre for Southern Africa KASA (Kirchliche Arbeitsstelle Südliches Afrika), also takes a critical view of how refugees are treated in Germany. His essay emphasises that very few people from Africa arrived in the mass influx to Europe in 2015. At the time, most were from civil-war countries in the Middle East. He argues that the distinction made between "war refugees and economic refugees" particularly hurts Africans.

Bambu considers the distinction inadmissible. One of the major reasons that Africans become displaced, he says, is due to the "destructive" global economic order and unfair trade liberalisation. For example, African markets are flooded with subsidised agricultural goods from Europe – including chicken meat, dairy products and tomatoes. The result is that African farmers lose their livelihoods. So far, the demand for "fair" trade relations, as expressed by Gerd Müller, the German federal minister for economic cooperation and development, amounts to mere propaganda, Bambu argues, as long as it does not "translate into tangible policy".

In Okakarara, Namibia, young Ovaherero recall German colonial crimes.

Photo: picture-alliance/Wiebke Gebert/epa/dpa

REFERENCE

Henning Melber (ed.), 2019: Deutschland und Afrika – Anatomie eines komplexen Verhältnisses (only available in German). Frankfurt, Brandes & Apsel.

Ethiopia needs better infrastructure: rural women often walk kilometres to fetch water.

DEVELOPMENT FINANCE

Untapped potential

African countries find it difficult to sell government bonds to their diaspora. However, initial successes show that diaspora bonds could be a useful instrument for development finance. The German non-governmental institute Südwind has devoted a study to the subject.

By Mira Enders

Many people who are unable to find work at home seek their fortune abroad. Those of them who then earn money usually send a share of it to their family back home. As the authors of the Südwind study explain, more than 800 million people worldwide regularly receive such remittances. It is often their main source of income and is used to pay for doctor's visits, schooling and other things that help raise the family's standard of living.

In 2018, nearly $530 million was transferred in remittances to low and middle-income countries. The Südwind researchers believe that money could be used more efficiently if it not only benefited the remitters' own families but also financed larger development projects. Diaspora bonds – fixed income securities issued by governments specifically to seek support or investment from expatriates – offer an opportunity to do this.

The current Südwind fact sheet looks at the diaspora bond's track record. It is found to work well where migrants feel a patriotic duty towards their home country and have confidence in the government. High-income migrants are then happy to invest a portion of their savings in diaspora bonds. This is the target group to which governments should tailor their bond advertising. Südwind notes that India, Bangladesh, Pakistan, Lebanon, Sri Lanka and the Philippines have already managed to finance development projects in this way.

In Africa, however, diaspora bonds have so far been issued by only six countries – with mostly disappointing results. The pioneer was Ethiopia, whose government first issued a bond aimed at expatriates in 2008. The money was intended to help finance the energy company Ethiopia Electric Power. However, few investors came forward because the risks were considered high. Another attempt was made in 2011, this time with a bond to finance the construction of a dam on the Blue Nile, but it also failed because expatriates lacked trust in the government.

Ethiopia's Prime Minister Abiy Ahmed Ali tried again in 2018. Südwind reports that he appealed to compatriots in the diaspora to support the expansion of health care and water supply at home by donating a dollar a day to the new Ethiopian Diaspora Trust Fund. The fund is also intended to subsidise small and medium-sized enterprises. According to Südwind, however, only $4 million had been raised by May 2019.

Kenya issued its first bond in 2009, the study reports, raising the equivalent of €164 million for transport, energy and water projects. There then followed six more bonds, which were open to all investors, whether from Kenya or not. 2011 saw the issue of a first bond aimed exclusively at the Kenyan diaspora but it generated only a quarter of the targeted investment volume. Bonds for investors from any country have proven more successful.

A positive example of how diaspora bonds could work in Africa was furnished by Nigeria in 2017. Südwind explains that the government spent four years preparing the issue and managed to raise $330 million for infrastructure projects. The bond is part of the government's drive to reduce dependence on oil revenues. Given that Nigeria is by far the most populous country in Africa and also receives the greatest volume of migrant remittances, the conditions for the bond were favourable. In 2018, Nigeria registered total remittances of $25 billion– a figure that shows there is still plenty of scope for strengthening diaspora finance.

LINK

Südwind Institut, 2019: Fact Sheet: Unentdecktes Potenzial: Remittances und Diaspora Bonds für Afrika ("Fact sheet: Untapped potential: remittances and diaspora bonds for Africa" – available only in German)
https://www.suedwind-institut.de/alle-verfuegbaren-publikationen/fact-sheet-unentdecktes-potenzial-remittances-und-diaspora-bonds-fuer-afrika.html

Photo: picture-alliance/Yvan Travert/akg-images

Stranded in the slums

Living in slums – squalid and overcrowded urban districts inhabited by very poor people – is turning into a way of life in Zimbabwe.

An estimated one in four of the country's urban population, or about 1.25 million people, live in slums, according to 2014 United Nations data. And their numbers are growing. The World Bank estimates that Zimbabwe's urban population, currently numbering about 5 million people, is increasing by two percent each year.

Living conditions in the country's so-called informal settlements are horrendous. Many of the dwellings are built entirely of woven grass. In some settlements, such as Caledonia outside the capital Harare, huts are typically made of ageing and rusty metal sheets.

One of the residents of that district, 26-year old Saliwe Chirumanzi, lives with her two children in a metal shack whose roof leaks when it rains. "My husband went to South Africa in 2017 and never returned, leaving us in this shack," she says. "I can't move from here because I cannot afford to pay rent anywhere."

Her neighbours, a family of nine, occupy a two-room grass hut. "We are sheltering our relatives whose shack was destroyed by fire two months ago," says 22-year old Mavis Chiwoko, one of the family members.

Despite such conditions, new arrivals stream into informal settlements every day. "People move from remote rural areas to urban areas in search of jobs and better living conditions," says Zisunko Ndlovu, an independent development expert.

Zimbabwe's rural-to-urban migration gained momentum in 2000 at a time of violent seizures of white-owned farms. The Zimbabwe Commercial Farmers Union says that about 30,000 farm workers lost their jobs following the country's land reform program. Many of them streamed to cities in search of work. Others crossed to neighbouring countries, including South Africa, for the same reason.

In 2005, Zimbabwe's government reacted to the growing urban squalor by destroying tens of thousands of illegal slum dwellings. That campaign left over 700,000 people homeless, according to the UN.

In the short term, the slum-clearance campaign sent many slum-dwellers back to rural areas. But with few work opportunities in the countryside, they eventually returned to the cities.

Growing overcrowding and the absence of running water, sewerage and electricity service are causing a public health crisis. The slums are seeing heightened rates of infectious diseases including tuberculosis, hepatitis and typhoid.

Meanwhile, little is being done to improve conditions in the slums. Zimbabwe has a housing shortfall of 1.3 million housing units, according to the Ministry of National Housing. Harare alone needs 500,000 homes.

The large shortfall reflects decades of neglect. During the administration of former President Robert Mugabe, most of the national budget went towards paying civil servants' salaries. That left little capital to build homes and convert fetid slums into habitable spaces.

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ROHINGYA

No hope for repatriation

More than two years ago, several hundred thousand Rohingya fled from Myanmar to Bangladesh. Since then, there have been two unsuccessful repatriation attempts, but so far no Rohingya has returned to Myanmar. Hope to solve the situation is dwindling.

By Mohammad Ehsanul Kabir and Palash Kamruzzaman

The Rohingya, a mostly Muslim ethnic minority traditionally living in Myanmar's northern state of Rakhine, are one of the most victimised groups of today's world. They are denied basic rights in Myanmar and have been displaced by ethnic violence time and again (also see Ridwanul Huque and Ashraful Azad in D+C/E+C e-Paper 2019/04, Focus section). The latest wave of Rohingya arrived in Bangladesh in 2017, raising their number in this country to around a million.

Bangladesh's response was generous and timely, sheltering refugees and providing for their basic needs. The response has been praised by the international community. However, the empathy of host communities and the government of Bangladesh is gradually withering away. The governments of Bangladesh and Myanmar started two repatriation attempts, but both were unsuccessful because the Rohingya were – and are – too afraid to return.

The reasons for their reluctance are obvious.

- First of all, since the military-led violence in 2017, the destruction and burning of remaining Rohingya villages continued throughout last year. In their place, new homes are being built by Myanmar's other ethnic groups.
- Second, representatives of the Rohingya have made it clear that the main prerequisites for returning are to be granted the right to citizenship and freedom of movement. On the contrary, Myanmar offered only National Verification Cards (NVC), usually issued to foreigners, and life in containment camps euphemistically called "reception centres".

Most of the refugee camps in Bangladesh are in Cox's Bazar, where the mass of displaced Rohingya now outnumbers the local population. Overcrowding means encroachment of forests and environmental degradation, high commodity prices and decreasing opportunities for making money. The purchasing power of the host communities is declining. Moreover, criminal gangs are increasingly targeting the Rohingya – for drug-peddling, human trafficking et cetera. The tensions between the host community and the refugees are now reaching an alarming level.

Since the second failed repatriation attempt in August 2019, it is palpable that some sections of the media and civil society are casting a bad light on the Rohingya. However, we have observed Rohingya en masse expressing their gratitude towards the Bangladesh government and the host community. Various interest groups in, around and outside the camps are pulling various strings. In the era of social media, rumours spread fast, fuelling the frustration of the host community and the Bangladeshi government. There is a potential risk of serious conflict, particularly where Rohingya now live in close contact with host communities. All stakeholders are facing major challenges.

Up until now, there is no guarantee that Rohingya returning to their homeland will escape state persecution, abuse or atrocities of the kind that made them flee in the first place. It is indisputable that the Rohingya must be repatriated with safety and dignity. China, India and Russia are staying apparently silent, however, and thus protract the crisis. Symbolic empathy from other major global players is not leading to any effective solution either. While support from numerous humanitarian actors has so far kept the refugees alive, tensions may explode soon. If the crisis is not revolved, it may morph into an issue of global security.

Rohingya refugee camp in Cox's Bazar.

Photo: Kazi Salahuddin Razu/picture-alliance/NurPhoto

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ELECTION FRAUD

Newfound faith in legal system

Malawi's Constitutional Court has annulled presidential elections that had been held in May 2019 and supposedly confirmed Peter Mutharika, the incumbent, in office. The judges' decision has boosted trust in the judiciary. It also sets an example on how to deal with election fraud in Africa.

By Raphael Mweninguwe

The court in Lilongwe, Malawi's capital, determined that the results of the May 2019 election were manipulated and that Mutharika is therefore not the legally elected president. Healey Potani, one of the five Constitutional Court judges, said that the elections had to be annulled accordingly. A new election must now be held within 150 days from the day of the ruling.

According to the officially published results, Mutharika had prevailed with 38.6% of the vote, just barely beating Lazarus Chakwera (35.4%) of the opposition party MCP (Malawi Congress Party). Saulos Chilima of the UTM (United Transformation Movement) was said to have come in third with 20,2%. The MCP and the UTM then turned to the Constitutional Court, accusing the Malawi Electoral Commission (MEC) of cheating. They pointed out, for example, that various results had been doctored by use of Tipp-Ex.

The Constitutional Court ruled that the election indeed lacked credibility, thus contradicting international election observers from the EU, the Southern African Development Community (SADC) and other institutions. The observers had spoken of free and fair elections. This is only the second time in African history that judges annulled presidential elections. In 2017, Kenya's Supreme Court was the first ever to do so.

Corruption is quite common, and apparently there was an attempt to bribe the judges in the current case, with a high-ranking banker trying to intervene in favour of Mutharika. The banker was recently released on bail from detention.

TRIUMPH OF DEMOCRACY

The majority of Malawians celebrate the victory of democracy and justice, but Mutharika supporters consider the judgment to be partisan. In their eyes, it thwarts the will of the people. Mutharika has personally criticised both the judges and the opposition parties. The MEC has done so too. Both parties have asked to the Constitutional Court to halt the implementation of the judgment and also appealed to the Supreme Court, demanding a reversal. The Constitutional Court has rejected the proposition, but the Supreme Court must yet decide. Legal scholars do not expect it to reverse the decision of the Constitutional Court.

Supporters of the opposition have been demanding the resignation of Jane Ansah, the head of the MEC, since May. Their pressure increased after the annulment judgment. They insist that she must not organise the next election. In mid-February, some 6,000 protesters rallied in front of the MEC offices in Blantyre and Lilongwe, locking the doors with chains. When this edition of D+C/E+Z was being finalised, Ansah was still clinging to office and said she would only resign if the Supreme Court confirmed the judgment passed by the Constitutional Court.

There have been recurring opposition rallies throughout the country ever since the controversial election in May. People neither trust the MEC, nor the government-run media, nor the police, nor the judiciary. While the court case was going on, the Armed Forces assumed responsibility for monitoring protest rallies.

The judgment has considerably boosted people's faith in the judges however. Mustafa Hussein, who teaches political science at the University of Malawi's Chancellor College, says that many people did not expect it and that it has changed the political dynamics. He believes it will have an impact on how elections must be managed in the future.

An interesting side aspect, according to Hussein, is that the Supreme Court not only dissolved the cabinet, but also reinstated Chilima as vice president. That is the office he previously held in the past legislative term, before running against Mutharika in the May elections. Since then, the two are not on talking terms, and it is expected that Chilima's role will be only ceremonial with no responsibilities whatsoever.

Opposition party supporters celebrate following the Constitutional Court's ruling in Malawi's capital Lilongwe.

Photo: Thoko Chikondi/picture-alliance/AP Photo

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CHILE'S NEW CONSTITUTION

Citizens speak up

Despite an atmosphere of general distrust of politics, Chilean citizens are actively debating a new constitution, which supporters hope will lay the foundations of an egalitarian society.

By Javier A. Cisterna Figueroa

Ahead of a referendum set for 26 April on whether to have a new constitution and who should write it, Chile is seeing an explosion in public discussion about the country's future. This surge in public debate is an encouraging sign, if one considers the recent wave of violent protests in Chile, and the general atmosphere of mistrust of politicians.

Chile has started a process to replace its 1980 constitution, which was adopted during the rule of Augusto Pinochet, a military dictator. Critics say the current constitution has fostered growing income inequality and an inadequate social safety net.

The road to a new constitution will be a long one. Under a political agreement following violent street protests last November, Chileans will vote in April whether they want a new constitution. They will also decide whether the text should be drafted only by members elected directly to a constitutional convention, or by a mixed group of newly-elected members and members of the national Parliament.

If Chileans vote "yes" to a referendum – which seems likely – then a second vote in October will elect the members of the drafting group. A third vote, to be held in March 2022, will accept or reject the new constitution.

The agreement to hold a referendum helped to stop violent demonstrations last autumn against the government of Sebastián Piñera, the conservative President. Protesters had objected to the high cost and poor quality of public services, inadequate health care, the low level of pensions, income inequality and market-radical orthodoxy in general.

Accordingly, much of the current debate deals with bread-and-butter issues such as raising the minimum wage, increasing the basic state pension and reducing prices for public services. Other discussions focus on broader issues of income equality and democratic participation.

The vote in April to draft a new constitution would still leave open whether market competition is to be rejected as a guiding principle, or whether it will go along with a stronger social safety net. The answer depends in part on who is elected to write the constitution.

Demonstration for a new constitution in Santiago de Chile in January 2020.

Photo: picture-alliance/AA

DEBATING THE FUTURE

A variety of citizens' groups has stepped forward to argue for direct representation of the people in a newly elected constitutional convention.

Women's groups, for example, want to see more women involved. They launched the "Never Again Without Us" campaign, which advocates for a stronger female voice. Women hold only 35 out of 155 seats in the current parliament. If women were represented in the constitutional convention in proportion to their share of the population, that would be a revolutionary leap.

Indigenous peoples are also pushing for a stronger say. They have the support of urban groups, which have joined indigenous organisations on questions of restitution of land, cessation of violence and environmental protection. Most of these groups say all members of the constitutional convention should be directly elected, to ensure the new constitution reflects people's real concerns.

One sign of the strong public interest in the topic is that people are already registering to vote. Some 367,000 people have done so, and 115,000 of them have registered as new voters. Another indication is that, when protests engulfed the country in November, the number one choice of reading material was the current constitution. Similarly, last December 1,200 people attended an event in the Biobio Theatre, the largest such venue in the country, to hear a conversation among law experts.

Public debate is intensifying, while trust in the political class seems to be further eroding. A nationwide survey last December gave President Piñera's government a six percent approval rating, and congress – which is mainly in opposition – a three percent approval rating. The referendum will obviously be very important – and it is a good sign that Chileans are increasingly inclined to talk with each other in search of solutions.

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Letters to the editor

EMBELLISHED IMAGE OF NAIROBI

Nicholas Hollmann in D+C/E+Z e-Paper 2020/01, Focus section: Transport infrastructure

I have been living in Nairobi for four years. I move around in the city a lot, but even though I would like to go by foot or ride a bicycle, I always use the car. Since I first came here, nothing serious has happened in terms of expanding sidewalks or bike lanes. The city still has only one bike lane, stretching two kilometres along UN Avenue. It is hardly useable, however. Sidewalks only exist in prosperous neighbourhoods.

I find it questionable to publish an essay that does not tackle day-to-day reality, but only relates plans and projections. It should be clear that having a plan is something completely different from implementing it.

Given that D+C/E+Z has readers, I expect the next group of visiting members of Germany's Bundestag to ask me to show them the positive examples of traffic planning in Nairobi. That will result in disappointment and the question why Germany is supporting development cooperation at all. Embellishing things only helps in the short term – if at all.

Dr. Jan Cernicky, Konrad-Adenauer-Foundation, Nairobi

TRANSFER ODA POLICYMAKING TO EU

D+C/E+Z e-Paper 2019/12, Focus section: EU

As handled so far, Germany's bilateral official development assistance (ODA) has achieved some results in specific partner countries and sectors, but it nonetheless lacks a serious perspective. Sustainability is definitely too poor. ODA should become an example of transferring policymaking to the European level and boosting the role of the EU.

Achieving greater sustainability in development cooperation is a challenge that the 27 member states must jointly rise to longterm. It is equally important to establish equitable trade relations with developing countries. As a reliable partner, the EU must ensure that multiple global problems are solved.

Wolfgang Meinecke, Stendal

IMPORTANT TOPIC DESERVING ATTENTION

D+C/E+Z e-Paper 2019/10, Focus section: Faith and politics

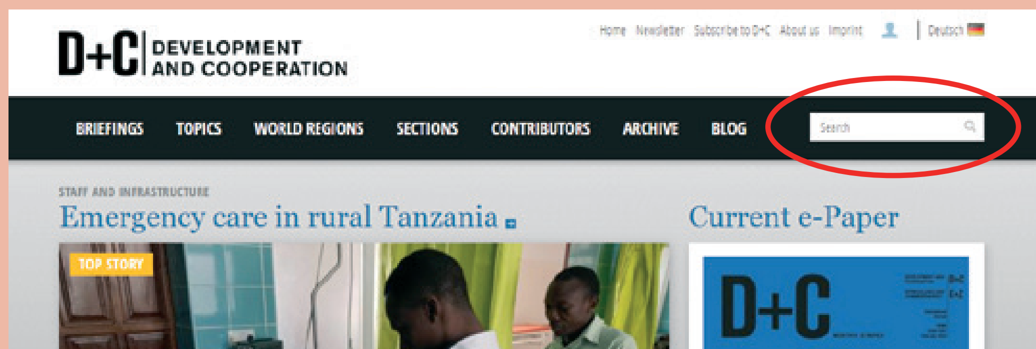
In my eyes, the editorial team deserves praise. The topic "faith and politics" gets far too little attention in Germany, as far as I can tell. One reason is probably that there is very little competition among different faith communities in Germany. Therefore, it is all the more urgent to make people aware of religious faith often being manipulated for right-wing politics. South Asia offers striking examples.

I would, however, appreciate if your website were organised in more intuitive ways, enabling readers to find contributions from the print issue faster.

Rainer Hörig, Bonn

EDITORIAL TEAM'S ADVICE

The search engine on our website **www.dandc.eu** is quite reliable, and Google will also deliver fast results if you enter a good search word such as an author's name plus "dandc.eu".



Protesters in New Delhi's Shaheen Bagh neighbourhood in early February.

Photo: Makhija/picture-alliacne/NurPhoto

PROTEST MOVEMENT

Protecting the secular constitution

An unprecedented mass movement is currently opposing the Hindu-supremacist agenda of India's national government. Muslim women, in particular, insist that the country's constitution, which forbids discrimination on religious grounds, must be upheld. That Prime Minister Narendra Modi's party, the BJP, has now fared poorly in Delhi's regional elections, may indicate that its grip on the country is weakening.

By Arfa Khanum Sherwani

Winter nights are cold in New Delhi, the national capital. Nonetheless, a large number of women have been staying at a protest camp in Shaheen Bagh, a south-eastern neighbourhood, for over two months. Braving chilly winds, sitting on rugs on the road, with just a tarpaulin sheet over their heads, the women show courage and resilience.

Shaheen Bagh has become a national symbol, and similar camps have popped up in many places. Not all participants are Muslim, but many are. Provocateurs have tried – but failed – to trigger violence several times. Nonetheless, at least two dozen protestors have allegedly been killed in police violence in various Indian states, with BJP-run Uttar Pradesh, the most populous state, topping the list with 19 deaths.

How the women articulate their cause is impressive too. Alima, a young mother with a baby in her arms, told me in Shaheen Bagh: "If we do not protest today, we might lose our citizenship tomorrow. Our constitution gives us the power to fight for our rights. We cannot allow Modi to change our constitution. People of all religions cooperated to give us this constitution."

The women have ample reason to be concerned. Current government policies indeed add up to putting at risk the citizenship of many poor Muslims who lack proper documents. The recent Citizenship Amendment Act and plans for a National Register of Citizens show this quite clearly (see box next page). Indeed, the informal marginalisation of the Muslim community is increasingly giving way to targeted Islamophobic action by the national government. The founders who wrote the constitution wanted India to be a pluralistic and democratic nation. By contrast, the politics practiced by the BJP in the past six years give enough evidence that it wants India to be a Hindu nation.

Many cities have seen huge rallies opposing discriminatory legislation in recent weeks, often with hundreds of thousands of participants. People of all communities were involved. There is no doubt, however, that Muslim women are playing a leading role. Their protest camps have become permanent symbols of non-violent resistance.

Delhi is burning

After Arfa Khanum Sherwani's contribution was finalised, violence erupted in northeast Delhi, not the Shaheen Bagh area discussed by her. Aggressive rhetoric by a local level Hindu-supremacist leader triggered street fighting between Hindus and Muslims, but as the riots continued for several days, they looked ever more like a systematic anti-Islamic pogrom. Even Mosques were set ablaze. It would suit Hindu-chauvinist forces to turn a dispute over constitutional principles into a clash of faith communities. Whether the worst was over when this issue was finalised, was impossible to say. More than 30 people had been killed. dem

The self-confident assertiveness of Muslim women was iconic right from the start of what fast became a nation-spanning movement. When, in mid-December, the police attacked peacefully rallying students at a Delhi-based university with tear gas and batons, two female students in hijab, Ladeeda and Ayesha, confronted officers to protect a male friend. Video clips of their brave intervention went viral, and in a matter of few hours, thousands of students across university campuses in India were protesting against police brutality.

Muslim women are often considered an oppressed group who are taught to be submissive. This image is prevalent not only in India, but the Indian government has a particular pattern of faking concern for their fate. In Shaheen Bagh, however, Muslim women in headscarves are proudly holding up the national flag. They recite the preamble of the constitution, demand "azadi" (freedom) and refuse to be treated as second-class citizens. Fearless women in hijab are thus challenging the prime minister, undermining his carefully crafted strongman image. Some are old, some are young, and most are homemakers protesting for the first time.

To what extent the movement will succeed in forcing the government to backtrack remains to be seen. What is obvious, however, is that the constitution still enjoys mass support. The majority of Indians know that India is a diverse nation and cannot be anything else. The BJP won its dominant parliamentary majority with only about 38 % of the vote in last year's general election. In absolute numbers, that share amounts to half of all Hindus at most.

To tell by the results of the recent assembly elections in Delhi, the BJP's grip on India may be weakening. Modi's party won a little over 10 % of the seats. It had tried to mobilise anti-Muslim sentiments, for example, by stoking fear of Shaheen Bagh protests being geared to establishing an Islamic state. It is encouraging that most people in Delhi did not buy that hateful propaganda. The plain truth is that the protest movement is firmly based on India's constitution and that the majority of India's citizens appreciate our constitution.

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Muslims' plight in Modi's India

With about 200 million people, Muslims are India's largest minority. Given that they are particularly affected by Prime Minister Narendra Modi's Hindu-supremacist agenda, many of them have become activists in the recent protest movement. It erupted after the national parliament passed a law that discriminates against Muslims.

The Citizenship Amendment Act (CAA) grants refugees from Pakistan, Afghanistan or Bangladesh a fast track to Indian citizenship if they fled for religious reasons. The problem is that the CAA explicitly excludes Muslims, even though Islamic minority groups such as Shias or Ahmadias often suffer hardship in the countries concerned. India's constitution forbids faith-based discrimination, but the government does not care.

The CAA fits a pattern. In the second half of last year, the national government pioneered a scheme to identify illegal immigrants with a particular focus on Bangladeshi Muslims in the state of Assam (see my comment in the Debate section of D+C/E+Z e-paper 2019/11). There are plans to roll out the scheme all over India. The buzzwords are National Register of Citizens (NRC) and National Population Register (NPR) (see blogpost on D+C/E+Z website). Poor people who lack proper birth certificates or similar documents would be at risk of losing their citizenship. As most Indian Muslims tend to belong to low income groups, they would be affected in particular.

Since Modi first became prime minister in 2014, harassment of – and violence against – Muslims has mostly been informal, though certainly systematic. For example, Hindu-supremacists, who argue that cows are holy to them, have accused Muslims of having eaten beef and killed them. After Modi's party, the BJP, again won general elections last year, repression has increasingly become official government policy.

For example, the national government stripped Kashmir, previously the only Muslim-majority state, of its special rights and turned it into two separate union territories under its direct control. Large parts of Kashmir have not had access to the internet since August 2019. Recently, it was reported that the Kashmir police was using the stringent Unlawful Activities (Prevention) Act against those who are using a VPN (virtual private network) or proxy servers to access social media websites. According to the government, this was done to stop "misuse of social media sites by miscreants to propagate the secessionist ideology and to promote unlawful activities".

It adds to the worries that India's independent Supreme Court recently cleared the way for a Hindu temple in Ayodhya on the very plot of land where the historic Babri Mosque stood until 1992. It was torn down by a mob of Hindu fanatics. The event triggered deadly riots all over India, as well as Pakistan and Bangladesh. The Supreme Court case concerning what to do with the land had been pending for decades. Hindu supremacists regularly demanded that the temple must be built (see my article in the Focus section of D+C/E+Z e-Paper 2018/05). aks

Substandard infrastructure is a defining feature of Lebanon's Shatila Palestinian refugee camp in the south of Beirut.

Photo: picture-alliance/Valery Sharifulin/TASS/dpa

REFUGEE CAMPS

Infrastructure reflects status

Refugee camps are established as a temporary solution – to accommodate refugees until they can return home. In reality, however, they often remain in place for years or even decades and sometimes even become formal urban settlements. Examples can be found in Lebanon. Since the original camps were not meant to be permanent, their infrastructure no longer meets current needs. But there are also examples of things being handled in a better way, and the key is social inclusion of the newly arrived.

By Mona Naggar

Burj Hammoud is a municipality in the sprawling conurbation of Greater Beirut. Located to the north of the Lebanese capital, it is an example of how a neighbourhood founded by refugees can develop. The majority of its inhabitants are Armenian, descending from people who were displaced by the Turks in the early 20th century. Thousands were deported from their homeland and expelled to neighbouring countries. That is what happened to 68-year-old Arpi Mangassarian's grandparents, who escaped the genocide by fleeing to Lebanon. Mangassarian has observed and closely monitored the development of her neighbourhood – both as a resident and an urban planner.

Mangassarian explains that some of the Armenian refugees who reached what is now Lebanese territory initially found shelter at Karantina, a refugee camp near the port of Beirut that no longer exists. Other refugees, on the orders of the ruling French mandatory authorities, were accommodated at Burj Hammoud, which was a wasteland at the time.

Many remained there. In the 1930s, Armenians began to buy land in Burj Hammoud and build modest homes on it. "Some plots had an area of just 40 or 35 square metres," Mangassarian says. On larger plots, up to 100 square metres, several houses would be built. "Most homes consisted of only two rooms: one for living in, the other a workshop."

The refugees began to put down roots and build a new life. In 1924, they were granted Lebanese citizenship. The Armenian quarter became a major centre for leather and craft workshops. However, Mangassarian has seen the 1930s and 1940s planning fall behind living standards: "Some residents feel the apartments are too small and they complain there is not enough parking. They are moving out of the area."

The streets of Burj Hammoud are narrow. The small, two-storey houses are densely packed together. Thanks to wide access roads and a two-lane urban motorway built in the 1990s, however, the area's people enjoy good connections to Beirut. That reflects how well the Armenian community has become integrated in Lebanese society. And as soon as a property in Burj Hammoud falls vacant, new occupants move in. The place is a magnet for today's refugees – people fleeing the war in Syria and migrant workers looking for low-cost accommodation.

POORLY EQUIPPED PALESTINIAN CAMPS

Palestinians are far less well integrated in Lebanon than Armenians. They were displaced when the state of Israel was founded in 1948. Some sought refuge in Lebanon, where camps were set up all over the country by international organisations. The lack of integration is clearly visible in the refugee camps, three of which now exist in Beirut.

One is Shatila, in the south of the city, flanking the urban motorway to the airport. There is no gate or checkpoint marking a boundary between the camp and the surrounding area. But anyone travelling between the two cannot fail to spot the difference. Political symbols, such as the Pales-

tinian flag or images of Palestinian political leaders, send out a clear message that Shatila was not made for Lebanese people. So does the grim infrastructure.

Shatila opened in 1949 and was designed to accommodate around 3,000 refugees. Today, far more people are crowded into the same area – mostly Palestinians but also Syrian refugees and migrant workers. There are no precise population figures. The neighbourhood grows vertically. People build new floors onto fragile-looking houses. The streets are narrow, only pedestrians and motorcycles can pass. Sunlight barely penetrates. There is no functioning sewer system. A damp putrid smell hangs in the air. Dangling power cables are a ubiquitous sight and water drips from leaking overground pipes. Shatila long ago became a slum, one of the poorest areas in Beirut.

The situation reflects the status of Palestinian refugees and their recent history in Lebanon (see my article in D+C/E+Z e-Paper 2019/04, focus section). Although they have been in the country for more than 60 years, they have only limited access to Lebanese educational institutions and the job market. They are also subject to discriminatory laws, such as those restricting access to social security and prohibiting land ownership. Naturalisation is a taboo issue.

The camps are administered by the Palestinian political factions. UNRWA (United Nations Relief and Works Agency for Palestine Refugees) is responsible for education and health care but has been struggling for years with declining funding. The Lebanese government sees Shatila and the other Palestinian camps as temporary institutions. They are located on Lebanese soil but treated as extraterritorial. The Lebanese state is present only when security issues are at stake.

What all current and former refugee camps have in common is traffic jams on the access roads. People in Beirut mostly move about in private cars. About one half of the household owns one car, and about one quarter even has two. They are used even for short distances. Public transport is underdeveloped and based on taxis, share taxis and minibuses, which serve standardised routes. Private ownership is dominant.

After the Civil War, which lasted from 1975 to 1990, efforts were made to rebuild Beirut's centre, but serious traffic planning was never been done. Neither public transport nor the street network have been expanded. The rehabilitation of the railway system, which was set up in the 19th century and discontinued in the mid-1970s, got stuck in planning stages and never took off.

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Informal refugee settlements

According to the UN Refugee Agency (UNHCR), more than 920,000 Syrian refugees are registered in Lebanon. Thousands more are in the country, but lack formal documentation. It is estimated that about 1.5 million Syrian refugees have fled to Lebanon.

Unlike during the Palestinian refugee crisis 70 years ago, the Lebanese government decided not to rely on camps in which people would centrally be taken care of. One reason was the experience with the Palestinian camps which became permanent settlements. The Lebanese authorities do not want something like that to happen again (see main story).

Syrian refugees are thus now dispersed all over the country and are mostly left to themselves. More than one third of them live in the Beqaa Valley in eastern Lebanon. This is an agrarian region with rather poor infrastructure and a struggling economy. Informal settlements mark the landscape. The makeshift huts are made of plastic tarpaulin and wood, dotting land formerly used as fields. The residents pay rent, though some owners allow them to stay free of charge.

The new settlements are typically located outside villages along main roads or behind the villages. The feeder roads that lead there are generally in poor condition. Many are mere dirt tracks. Most people walk to the main road to take a collective taxi or a minibus if they want to go to a town. As is true in Lebanon in general, there is hardly any public transport in the Beqaa Valley. The train line that linked Damascus to Aleppo in the past was discontinued in the mid-1970s, shortly after the Civil War erupted.

Lebanese authorities destroyed walls in a Syrian refugee camp – refugees are only allowed to settle in tents.

Photo: picture-alliance/AP Images

In winter, the condition of the dirt roads deteriorates. Sometimes, they cannot be used at all. In this sense, the refugees living in settlements along the main roads are at an advantage. The downside is they have traffic. There are no sidewalks or bicycle trails, so pedestrians and playing children are at serious risk of accidents. Due to many deadly incidents, the road from the village Bar Elias to Baalbek is now called "the road of death". It passes by several informal settlements. mn

BUSINESS INCUBATION

Building digital nations

All over the world, tech hubs are proliferating. They offer promising entrepreneurs support and provide an environment for developing ideas and products. The approach is basically same all over the world, but there are particular challenges in developing countries, for example in West Africa.

By Ely Manel Faye

Leapfrogging can accelerate development dramatically. While only very few Africans have fixed-line telephones, West Africa alone now has about 185 million smartphone users. Digital technology makes it possible to skip some stages of development that occurred in rich nations. It is therefore important that ever more young Africans have been leveraging technology in the past 20 years. They have found digital solutions for improving people's access to financial services or health information for example.

Tech hubs support this trend. They offer a range of services to entrepreneurs, including workspace, mentoring, technical tools, infrastructure, training, networking and access to funding.

According to the GSMA, an international trade organisation of mobile-phone operators, the number of tech hubs in Africa doubled to 618 in the years 2016 to 2019. In Senegal, the CTIC incubator founded in 2011 has supported more than 170 start-ups. In Ghana, the Meltwater School of Technology (MEST) was created in 2008 and is considered to be one of the most dynamic tech incubators in West Africa. It combines business training with tech expertise and seed funding (see interview with Veronica Mulhall in the Focus section of D+C/E+Z e-Paper 2020/01).

A tech hub's impact depends on many things. To what extent they can generate jobs and incomes is determined by external and internal factors. The external factors include an economy's maturity, public policies, the availability of skilled personnel and the business climate in general (also see SalaMartu Duncan and Michael Konow in Focus section of D+C/E+Z e-Paper 2020/01). Internal factors include how a tech hub is managed, what legal status it has, what it specialises in and other matters.

Most West African tech hubs are quite young, and so are the companies they have incubated. Most were launched within the past five years. They typically specialise in fin tech (financial technology), e-agriculture, e-health, e-logistics et cetera.

Staff at Solutroniq.

Photo: Faye

There is definitely a new culture of African entrepreneurship. To what extent it will transform labour markets and entire economies remains to be seen. They are not expected to generate significant number of jobs themselves, but they are likely to boost the development of other sectors and value chains. The risk level of young start-ups is high, and success rates are low. Typically the companies are quite small and only employ a handful of highly educated staff. They hardly hire workers with low or even no skills. At the same time, these tiny companies may well enhance long-term value creation in various sectors.

That is happening in agriculture for example. Innovative fin-tech applications now give farmers the access to credit that they traditionally lacked. With a similarly useful impact, small start-ups with only two or three employees have launched e-agriculture platforms that provide accurate information concerning market prices or humidity, considerably improving their livelihoods.

Access to early-stage funding is one of the biggest challenges young entrepreneurs face. Commercial banks shy away from lending to young entrepreneurs who may have an interesting, but untested idea, but lack a business track-record and proven management skills. Tech-hub support enhances an entrepreneur's eligibility for loans.

GOVERNANCE MATTERS

To really prove transformative, tech hubs and start-ups need a good business environment. Governments must build digital nations, capable of using technology well. They must ensure high-quality education

and appropriate infrastructure. Laws and regulations have to be sensible – and they must be enforced properly.

Tech hubs can help to make these things happen. For example, they can provide public authorities with insights concerning how to reform education systems. Universities, for example, should not simply train engineers. They should cooperate closely with tech hubs and private businesses in general, sharing resources and research results.

Most African tech hubs are privately owned. They must cover their costs and make profits. One implication is that they are sometimes overly careful in choosing what start-ups to promote. The long-term potential of an entrepreneur's idea may matter less to them than whether that start-up will be able to pay the rent and the incubator fees.

Well-designed government action can make a difference in this respect. Therefore, Senegal's recently established Délégation à l'Entreprenariat Rapide (DER) is promising. This new government agency is running a public investment fund in support of early-stage start-ups.

To a considerable extent, international development agencies are supporting tech hubs too. In 2016, the AFD (Agence Française de Développement) launched the Africa Innov# programme. Among other things, it grants interest-free loans to start-ups from selected West African tech hubs. The World Bank's infoDev programme has created or supported hundreds of incubators across Africa. They deal with climate technology, agriculture and digital applications. GIZ recently announced a partnership with Orange, the telecoms multinational, to co-invest € 30 million in the Orange Digital Center. This incubation and training programme will be run in 14 countries, of which seven are West African.

It makes sense to include well-established private-sector companies in a tech hub's ecosystem because it improves the outreach to different business sectors. The better a start-up is linked to existing companies, the more likely its innovations will be applied. Moreover, it is important to network internationally. Tech hubs should coordinate among one another, concerning, for example, what they specialise in. There is a policy dimension too. In exchange for subsidies, tech hubs could be made to work on the delivery and safeguarding of public goods for example.

It is important to identify what innovations have the greatest potential for driving job creation in other sectors and thus promote social inclusion in general. For this purpose, cooperation with different stakeholders, including government agencies and universities, is essential. Africa needs digital nations – and tech hubs, on their own, will not bring them about.

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People waiting to see a doctor at the St. Francis Referral Hospital in Ifakara, Tanzania.

Poverty and disease

Poor people with weak immune systems are especially prone to falling ill. At the same time, sick people are particularly likely to plunge into poverty because their scope for earning money is reduced precisely at a time when considerable spending on health care becomes necessary. The weaker a country's public health-care system is, the more devastating this vicious circle proves to be. In those places, health problems persist even after becoming negligible where access to professional facilities are generally taken for granted.

This focus section directly relates to the UN's third Sustainable Development Goal (SDG): Good health and well-being. It also has a bearing on the other SDGs.

Photo: Martin Rohacek

EBOLA

Five years later

Sierra Leone was devastated by the Ebola outbreak from early 2014 to late 2015. Some lessons have been learned – especially in regard to community-based action. Whether the country is properly prepared for another major health crisis remains an open question nonetheless. It is scary to consider what suffering the new coronavirus might cause, should it prove more dangerous than currently assumed.

By Shecku Mansaray

Sierra Leone shares the Mano River region with Liberia and Guinea. The three countries are poor and tightly woven together socio-culturally. When one of them sneezes, the other two are likely to catch a cold.

In the early 1990s, Liberia's civil war spilled over, and fighting caused terrible suffering for 11 long years in Sierra Leone. The next big crisis was the Ebola outbreak that haunted the region for 3 years. It started in Guinea in 2013 and then crossed over to Liberia and Sierra Leone. The first cases in Sierra Leone were registered in March 2014. It took 20 months before the country was finally declared Ebola-free in November 2015.

According to the World Health Organization (WHO), Ebola killed 11,323 people in the three countries. The real number was certainly higher since not all cases were registered. The WHO reckons that more than 17,000 patients survived. Their suffering must not be underestimated however. Many are permanently disabled, orphaned or widowed. Most are now poorer than before. All of them are traumatised – and so are their families and communities. Moreover, the entire population of the three countries was stigmatised. Our world region was basically cordoned off, which caused additional economic hardship.

Ebola was previously unknown in Sierra Leone. Earlier outbreaks had occurred in faraway countries like the Democratic Republic of Congo. Our region's healthcare systems were always weak, so health professionals were neither aware of Ebola's symptoms, nor of how to prevent, treat and cure the disease. Making matters worse, the initial fatality rate was announced as almost 100 %. We felt as though we were awaiting imminent death.

Ebola spread to Sierra Leone through porous borders. Many people regularly do business in neighbouring countries; others have family there. There is a pattern of low-income persons, who live hand to mouth, crossing borders in search of livelihoods.

Our poorly equipped health facilities are miles apart. Fearing Ebola infections, people began to avoid them. After the first fatalities among health staff, health facilities – whether government run, private or charitable – began to lack staff. The government even ordered them to close (see box next page). Some faith-based health centres bravely kept working nonetheless.

The outbreak of Ebola had indirect impacts too. As the UN Development Programme (UNDP) pointed out in 2015, "it severely disrupted social life and economic activities, with gruelling effects on household livelihoods and the national economies in general." The psychological blow exacerbated feelings of helplessness.

Sierra Leone's government was obviously overburdened. The health minister initially downplayed the crisis, and was then sacked. The president established a National Ebola Response Committee (NERC), headed by a retired military officer. By the time it was working properly, Ebola had spread across the entire country.

Over time, however, the NERC proved a success. Several factors played a role:

Health worker treating Ebola patient in Sierra Leone in early 2015.

Photo: Seamans/picture-alliance/ZumaPress

- While the international community was painfully slow to come to the aid, there eventually was a big influx of much needed foreign expertise and funding.
- While the NERC and its district-level subsidiaries operated with military discipline, they adopted an open-door policy, welcoming all parties on board.
- A community-based response was spearheaded in eight districts, and the number of new infections began to dwindle.

In retrospect, it is clear that the open and participatory "all on board" policy enlisted was good. It included everyone who

found the courage, resources and energy to join the fight. It allowed cross-fertilisation of ideas among health professionals, social workers, civil-society organisations, local authorities, security personnel, religious leaders and volunteers from all walks of life. No single entity can claim to be the sole owner of the success in the fight against Ebola.

Non-governmental organisations in particular assumed responsibility. For example, ten local partner organisations of Bread for the World (BftW), a Protestant German NGO, managed to recruit over 4,000 young men and women as community health volunteers.

Trust at the grassroots level was essential. Citizens had to be convinced of strictly observing Ebola rules. That meant no hand shaking, no hugging, no public gatherings, no washing of corpses before burial, no football games, no attendance of schools, colleges or universities, no touching of strangers, no Christmas. On the other hand, hand washing became mandatory before entering any house, office or clinic.

Such behavioural change is hard to sustain. Poverty made it even harder. People frequently found themselves in situations where they had to decide between defying the rules of Ebola prevention and eking out a living. All too often, Ebola won.

Faced with catastrophe, a least-developed country needs international support. International non-governmental organisations proved more dynamic than multilateral agencies and donor governments. I recall

a cheering crowd at the airport welcoming the arrival of essential medical supplies in support of BftW partners. The supplies were paid for by BftW and flown in by the German Air Force.

LESSONS LEARNT

Sierra Leone's health professionals now know what Ebola means and how to respond. Moreover, the huge number of community health volunteers will certainly prove helpful in a similar crisis. There recently was an incident of Lassa-Fever in Sierra Leone. The responsible health facility handled it professionally and effectively, inspiring hope that our health-care system is up to task. People's general awareness of health issues has increased too.

On the other hand, we know that our health system crumbled fast when first confronted with Ebola. It is scary to consider what harm the new coronavirus might cause should it spread to our country and prove more dangerous than currently assumed. On the upside, Sierra Leone has learned that community involvement is essential, and that should be helpful in any health crisis.

Depressingly, most pledges made by international agencies to support the post-Ebola recovery have not been honoured. Moreover, there has been a change of government, and the new leadership has de-linked Ebola-recovery from its development agenda. For public health to improve continuously, however, health considerations have to feature in each and every policy choice. One must hope that the established disaster-response mechanisms will be maintained at the local level.

Another lesson is that a poor, post-war country like ours is devastated long-term by such an overwhelming health crisis. Because investments stalled fast, including the mining sector, the economy has not fully recovered yet. Problems of unemployment and poverty have become worse.

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Slow start

Had international and national authorities responded faster and more competently when Ebola began to spread in Sierra Leone in 2014, the epidemic would have caused less harm.

Precious time was lost because Sierra Leone's health ministry initially shied away from convening all relevant parties immediately and involving them in coordinated action. Instead, it initially kept things relating to Ebola secret. It should have taken pre-emptive action. Its officers knew what was at stake because Guinea was affected first. Instead of strengthening the health system, they even ordered facilities to close.

Some 200 health staff died of Ebola in the early stages. The number would have been much smaller had the government provided timely information on safety procedures and preventive clothing. Only later did the government change its stance in view of the spreading epidemic (see main story).

The very slow response of the international community was disappointing too. The only institution to turn to for reliable information was the World Health Organization (WHO). At one point, it became clear to me that the WHO was expecting up to 60,000 dead in the three countries hit by the epidemic (Sierra Leone, Liberia and Guinea). This high number was shocking, particularly as the WHO had done little to prevent the spread of the disease. Its resident team in Sierra Leone had failed to advise our government properly in this regard in the early stages.

Ultimately, Ebola was brought under control. Coordinated action of all relevant stakeholders from multilateral institutions to grassroots initiatives made it possible. sm

HEALTH SERVICES

Good care for all

In many countries today, public health services are low-quality and cater only to the poor. Everyone else relies on private, but largely unregulated services. Neither the poor nor the prosperous are being served well. To improve matters, concerted action is needed to improve services, boost governmental oversight and strengthen public institutions.

By Andreas Wulf

Life expectancies are rising worldwide. Even in the global south it is no longer just a small elite that keeps getting older and older. One consequence of this development is that chronic, non-infectious health problems of aging populations increasingly figure in the global health-care debate. Since the turn of the millennium, they are getting more attention. They include chronic respiratory and cardiovascular diseases, cancer, diabetes, renal insufficiency, psychological and neurological problems as well as addiction (note contributions by Jeffrey Moyo on p. 29 in this issue and by Max Klein in D+C/E+Z e-Paper 2020/02, Tribune section).

For many people, the availability of medical services has rapidly expanded. The reason is that cities usually have a broad spectrum of health-care providers and urbanisation is reaching an ever greater share of the world population. Private health care, however, is often insufficiently regulated by the state, so patients and their families are frequently at the mercy of providers.

Bangladesh is a good example. Twenty years ago, wealthy Bangladeshis preferred to travel to Calcutta or Bangkok in order to be treated in private hospitals. Nowadays, there is a large number of private clinics in Bangladesh's large cities, including health facilities run by multinational corporations. They have many patients, even though the providers tend not to be subject to appropriate quality and price controls.

The cost of health care is a huge problem. It often drains the savings not only of poor people, but even of well-established middle-class families. That is the case when a family member needs an expensive cancer therapy or long-term dialysis treatment, for example.

In this context, the cost of medication in particular has long been the subject of intense debate. At the turn of the millennium, an international controversy broke out because antiretroviral drugs were unaffordable expensive even though they were life-saving in the long-term treatment of AIDS. It took an enormous amount of public campaigning to change the rules of the World Trade Organization (WTO) in a way that assured governments to use patent flexibilities and allow them to grant companies licences to produce generic versions if that is necessary to ensure public health. That decision was taken at the WTO summit in Doha in 2001, after Brazil and other countries had forged ahead and produced and made generics available using the existing but contested WTO exception rules.

In 2002, the HIV/AIDS-drugs were introduced into the WHO Model List of Essential Medicines, which until then did not include patent-protected drugs because of availability considerations. Together with new funding available from the Global Fund to Fight AIDS, TB and Malaria and other programmes, this cleared the way for the necessary resources to be provided so infected people could get treatment. Prices dropped fast from suppliers in India, Brazil and Thailand. In view of competition from these generic-drug producers, patent holders began to reduce prices too. It is now possible to provide long-term treatment to 24.5 million people around the world. While, at the beginning of the millennium, the WHO's goal of treating 3 million people by 2005 was considered by most experts completely unrealistic.

Despite such success, it remains disappointing that attempts to control the profit interests of large multinational pharmaceutical companies by making pricing, patents and research costs more transparent have mostly been ineffective. Only at the most recent World Health Assembly in May 2019, did heated debate erupt concerning a resolution on the matter. Unfortunately, Germany was one of the countries that did their best to slow things down. The plain truth is that, in the German delegation's eyes, national interests prevailed over global ones since pharma corporations contribute to Germany's export success.

Private hospital in Dhaka, the Bangladeshi capital, in 2007.

Photo: medico

At the same time, high costs of medication and health care in general are no longer just a problem for poor countries. The cost of an individual cancer therapy can eas-

ily run to six figures. The first truly promising gene therapies for rare diseases are now coming on the market, passing the mark of 2 million dollars per patient and year. Germany's public health insurances negotiate "discounts" with pharma companies on many expensive drugs. It helps to ensure care at the national level. However, this approach is completely non-transparent and is thus not a convincing alternative to enforcing transparency at the international level, as was the goal of the proposed resolution. Such multilateral action would, of course, also improve the negotiating conditions for smaller and poorer countries vis-à-vis the pharma multinationals. This debate will go on.

Another feature of the global debate is about what would be an "acceptable" basic package of care in resource-poor health systems. So far, infectious diseases and maternal and infant health are the priorities. Chronic diseases, which require constant treatment long term and often cause the greatest costs, are largely neglected, and prevention and promotive activities are largely limited to behavioural interventions focusing on things like healthier diets, more exercise and cutting back on smoking.

Universal health coverage is supposed to keep costs low. But when countries adopt a universal system, policymakers tend to shy away from the important question of how the right to quality care can be upheld for all citizens – whether rich or poor. The interests of the profit-maximising private sector interests often prove very powerful. While the WHO Framework Convention on Tobacco Control proved a success, a serious downside is that the sugar and soft drink industry learned its lesson from that debate. It has so far managed to block a similarly coherent control strategy in its sector.

MORE MEDICINE DOES NOT ALWAYS MEAN BETTER HEALTH

In general, it is appropriate to take a critical stance towards the health-care sector and its products. Scandals surrounding poor-quality silicone breast implants or artificial hip joints, for example, show that "more medicine" does not necessarily lead to better health.

Indigenous women rally for better health care in Brasília, the capital of Brazil, in August 2019.

On the other hand, patients are given too much, too little or the wrong care even in rich nations like Germany, as the national Advisory Council on the Assessment of Developments in the Health Care System has emphasised. This experience shows that defining the "package of care" does not suffice to ensure quality health care for everyone.

What is needed instead is a concerted effort. It must:

- improve the quality of health-care providers,
- boost public authorities' oversight and
- systematically strengthen public health care.

Today, public-health services are typically low-quality and cater only to the poor in developing countries, while everyone else takes advantage of private, largely unregulated health services. Neither group is being well served.

The current crisis of Brazil's government-run health-care system, SUS, makes this abundantly clear. It is based on the idea of providing free and universal access to all citizens. It is considered a model of care not only with regard to primary care, but also especially to secondary and tertiary care. During the first 15 years of the new millennium, however, many Brazilians became able to afford supplementary private insurances. The background was a booming economy and a centre-left government that redistributed profits of the commodity sector. In those years, private providers prospered, while primary health-care facilities began to be eroded as they became unattractive to both communities and health-care professionals. Ultimately, thousands of Cuban doctors had to be employed in order to ensure care for the (still numerous) poor.

During the severe recession that started in 2015, however, many people from the new middle class lost their private insurance. They must now rely on the SUS once again. Its primary health-care centres, however, have been further harmed by radical austerity. They are known for their innovative, multi-disciplinary "family health teams", but they are no longer in a position to provide good care. Therefore, ever more patients are resorting to the next level of public care, the outpatient departments of hospitals. These too are now overwhelmed.

The Brazilian example shows that it is problematic and short-sighted to make public health facilities focus on the poor and let better-off people rely on private providers. This division of labour may seem to make sense to "save" public funding, but it does not really do so. Social services' resilience to budget cuts depends on politically influential actors and classes not pull back from them. The promise of the Sustainable Development Goals (SDGs) is to leave no one behind. To live up to it, public health systems must ensure true universal access and must not deepen social disparities by giving different classes different options.

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Photo: Eraldo Peres/picture-alliance/AP Photo

VACCINES

A shot in the arm

Sub-Saharan Africa faces persistent poverty, wide income disparities, high rates of certain diseases and below-average vaccination rates. Research shows all these conditions are related.

By Hannah Hussey, Rudzani Muloiwa, Gregory D. Hussey and Benjamin M. Kagina

Poverty and ill health often go hand in hand. Indeed, the close link between poverty and poor health is a vicious cycle: each condition exacerbates the other.

Poverty can lead to illness by limiting access to clean water, adequate nutrition and education. In turn, illness can deepen poverty by imposing medical expenses, reducing the productivity of sick individuals and cutting the income of relatives who take time off from work to care for patients. Poor health can also have long-term effects when sick children cannot attend school and end up as less economically productive adults.

In Africa, the link between poverty and ill health is in plain view. On the health front, Africa is the continent with the highest infant death rates, a key indicator of poor public health. On the economic front, Africa is the world's most impoverished continent. The World Bank forecasts that by 2030, nearly nine out of every ten extremely poor people will live in sub-Saharan Africa.

In addition, Africa has the biggest gaps between haves and have-nots: the Gini index, a statistical measure of income distribution, shows that eight of the ten economies with the widest income disparities are in Africa.

Although Africa has a high burden of both poverty and disease, many of its diseases are preventable with existing vaccines. To improve Africa's health levels, governments and other key stakeholders need to improve access to vaccination. Ultimately, greater access to vaccination will lead to a reduction in poverty and income disparity.

Despite the demonstrable benefits of vaccination, its full potential has yet to be tapped in Africa. In 2018 only 76 % of African infants received three doses of the diphtheria-tetanus-pertussis (DTP) vaccine, compared to the global rate of 86 %, according to the World Health Organization (WHO). Rates of DTP vaccination are usually used as a key indicator of overall vaccine coverage.

Vaccination reduces the impacts of poverty on child survival and protects the most vulnerable children. Obviously, families who cannot afford treatment benefit most from disease prevention. Moreover, vaccination often serves as a gateway for individuals and communities to receive other health services. Vaccination has such a wide-ranging impact on communities that its role is important to achieving 14 out of 17 of the Sustainable Development Goals.

For vaccination programmes to succeed, they must be delivered to entire communities and repeatedly over many years. When vaccination coverage is high, herd immunity is achieved, so that even the few who are not vaccinated are protected. The fight against smallpox serves as a good example of the herd effect. Through vaccina-

Paying a price

Despite the availability of vaccination, 30 million African children under the age of five suffer from vaccine-preventable diseases each year. Even more devastating, half a million of these children will die from these diseases, according to the World Health Organization (WHO).

Part of the problem is the price of vaccines. In 2001, the total cost of vaccines for the six main vaccine-preventable diseases (polio, tuberculosis, measles, diphtheria, tetanus and pertussis) was $ 0.67 per person.

Since then, new vaccines against hepatitis, pneumococcus, rotavirus, rubella and human papillomavirus have been added to vaccination programmes in many African countries. This has increased the cost to $ 45.59 per person, excluding programme costs such as staffing, as well as the transportation and refrigeration of vaccines.

Despite this steep increase, vaccination remains highly cost-effective in terms of individual health, public health and economic productivity. Seen in the context of the benefits it brings, the cost of vaccination is actually low. The big challenge is that not everyone is able to afford the price and others are not willing to pay it. For this reason, public policy matters. To protect their people, African governments must continue to work to make it happen – and donor governments and initiatives like Gavi, the Vaccine Alliance, should continue to support those efforts.

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Immunising a Kenyan baby.

Photo: picture-alliance/Miro May

tion, the disease has been eradicated across all income groups worldwide.

NEW VACCINES REQUIRED

The suboptimal 76 % coverage rate for DTP vaccination is only one area in which progress is urgently needed to promote public health in Africa. Another area of concern is HIV/AIDS. In 2018 there were around 25 million people living with HIV in Africa, representing about two thirds of global HIV cases, according to UNAIDS, the Joint UN Programme on HIV and AIDS. UNAIDS also says there were 1 million new HIV infections in Africa in 2018.

Worryingly, HIV usually affects young adults, who are the most productive, making the economic costs of the disease high. While antiretroviral treatment has saved lives and turned HIV into a chronic condition, lifelong treatment has overburdened health-care services. As new infections continue to appear, a vaccine is desperately needed. Currently no vaccine is licensed in Africa for HIV, but several are being tested.

Like HIV, tuberculosis (TB) is also treatable and imposes a heavy economic burden in Africa. Each year there are around 2.5 million TB cases and about 500,000 people die from it, the WHO says.

While better diagnostic tests and treatments are being developed, a vaccine is also critical for fighting TB. Currently the BCG (Bacillus Calmette–Guérin) vaccine is given to newborns, protecting them from severe forms of the disease, but BCG can have poor protection against pulmonary TB. Research is under way to develop new vaccines and to test the effectiveness of revaccinating adolescents with the BCG vaccine.

Malaria is also a focus of attention. Despite being curable, the disease is still widespread. According to the WHO, an estimated 405,000 people worldwide died of malaria in 2018. The WHO adds that its African region has a disproportionately high share of the global malaria burden, with 93% of the world's malaria cases and 94 % of the world's malaria deaths occurring there in 2018.

GOOD NEWS

Obviously, an Ebola vaccination would be good too. During the West African epidemic from 2015 to 2018, clinical trials began on the Ebola vaccine rVSV-ZEBOV, which showed encouraging safety and effectiveness results. The vaccine is now being used in the ongoing epidemic in the Democratic Republic of the Congo. Although it is unlicensed, which means its full safety and effectiveness is still not fully known, this vaccine is being administered under a "compassionate use" initiative. This allows high-risk patients, for whom there is no other authorised medicinal product, to receive the vaccine. The approach makes sense because the risks of the vaccine are far below those of an Ebola infection.

Front-line Ebola workers in the DRC benefit from unlicensed vaccine protection today.

Photo: picture-alliance/Gael Cloarec/Le Pictorium/MAXPPP/dpa

Other good news in Africa is that government spending on vaccination has increased, and the continent has managed to maintain coverage rates despite a rapidly growing population, according to the Strategic Advisory Group of Experts on Immunization, an advisory group established by the WHO. This achievement is notable in the context of a rise in vaccine scepticism worldwide, which has led to outbreaks of diseases like measles, even in high income countries. Another piece of encouraging news is that following the last case of wild poliovirus in Nigeria in 2016, Africa is moving toward being declared polio free.

Vaccine research is also moving forward on the continent, with several new vaccines being tested and introduced. In 2019, authorities in Ghana, Malawi and Kenya began pilot-testing the first vaccine to be licensed against malaria, called RTS,S. While the vaccine does not provide complete protection, it represents progress as the first malaria vaccine to move beyond clinical trials. As in many other areas, on the matter of achieving full vaccination coverage, Africa has a long road ahead. But it is making progress, raising hopes that it can turn the vicious circle of poverty and disease into a virtuous circle of better health and rising incomes.

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STAFF AND INFRASTRUCTURE

Emergency care in rural Tanzania

Swiss doctor Martin Rohacek has shown that it is possible to provide adequate emergency medical care even in rural areas of sub-Saharan Africa. In 2015, with limited resources, he started to set up an emergency department at St. Francis Referral Hospital in Ifakara in Tanzania. The project was launched in close cooperation with the hospital, local partners and the Swiss Tropical and Public Health Institute. He elaborates on his work in D+C/E+Z.

By Martin Rohacek

An emergency department is vital for providing immediate and adequate assistance to seriously ill or injured patients. If such help is unavailable, that all too often amounts to a death sentence. Cases of severe sepsis or bleeding, for example, cannot be effectively treated in an outpatient clinic. Many patients do not get timely help, and diagnoses are frequently incorrect.

Setting up an emergency unit requires organisation, training and a certain amount of hardware. At St. Francis, we reorganised outpatient staffing to permit 24-hour emergency care. A three-shift work schedule was established. We also set up what is known as a triage system. It prioritises patients according to the severity of their illness or injury. Each patient is first seen by a nurse, who checks blood pressure, pulse, temperature and oxygen saturation and then assigns the patient to one of three urgency level categories based on a score card (South African Triage Scale, SATS).

This method allows us to identify critically ill patients and take them to the emergency room immediately. The emergency team can then make the diagnosis fast and start treatment. Less ill patients stay in the waiting room until they are seen by other emergency-unit doctors a bit later. Patients are registered and pay for the hospital service only once the triage process is completed. Emergency medication is similarly administered to patients right away and paid for later.

In the emergency room, staff can rely on good infrastructure. It includes four patient monitors, two ultrasound machines, a defibrillator, an electrocardiogram (ECG) machine, non-invasive airway management equipment, a suction pump, a nebuliser for inhalation medication and a thoracic drainage system. The equipment also includes rapid-test kits to determine blood-sugar levels, check for malaria, HIV and pregnancy. Urine tests, syringes, cannulas, gloves and intravenous fluid, catheters and emergency drugs are readily available. This year we plan to introduce a point-of-care system for blood gas analysis and a blood chemistry laboratory.

The emergency staff include six fully trained clinicians (medical doctors, clinical officers, assistant medical officers) and four junior doctors on internship (intern doctors on two-month rotation) as well as 13 nurses. It is important that staff continuously update their training in emergency medicine, ultrasound and echocardiography. This is done according to the "train the trainers" principle, where personnel with greater expertise instruct less experienced colleagues. Training takes place daily at the patient bedside, during daily handover reporting and in emergency and ultrasound courses.

Since our project was launched, we have trained around 30 physicians and nursing staff in emergency care. Nine clinicians, four of them working at the emergency department, have successfully completed the point of care ultrasound exam according to the standards of the EFSUMB (European Federation of Societies for Ultrasound in Medicine and Biology). They now supervise less experienced colleagues in daily practice and instruct others in ultrasound courses. A further 80 or so newly qualified young doctors have worked at the hospital for a year, gained insights into emergency care and ultrasound application.

We treat 36,000 adults and children a year at the emergency department. Journeys to the hospital are often long and arduous due to poor roads. Moreover, people in our region tend to have little money and

Doctor Henry Marique Mwigani performs an ultrasound examination on a trauma patient.

Photo: Martin Rohacek

no health insurance, while their farms demand constant attention. For these reasons, many patients only come to the hospital when their condition is advanced. Once diagnosed, patients in desperate need are first treated and stabilised in the emergency room and then transferred in better condition to the operating theatre or another ward. In the best cases, they can be discharged to go home.

We are able to treat the major ailments: sepsis and other infectious diseases such as pneumonia or malaria are tackled by rapidly administering fluids and antibiotics. In the case of accidents that result in internal injuries, we transfer patients directly to the operating theatre – for example to stop internal bleeding, to remove a ruptured spleen or to provide emergency treatment for a ruptured ectopic pregnancy.

Good cooperation across all specialised wards is extremely important. However, for some disorders we run up against limits. We do not have a CT scanner, so we cannot examine or treat head injuries to the standards achieved elsewhere. Nor do we have equipment for long-term ventilation, so we have to send severe pneumonia sufferers to a central hospital if they are in need of mechanical respiratory support. The problem is that this is often impossible because that hospital is 420 kilometres away. It takes a ten-hour drive on poor gravel roads to get there. We also have to transfer kidney-failure patients for renal replacement therapy.

Of all the patients we treated between July 2016 and June 2017, 46 % suffered from infectious diseases such as respiratory infections, urinary-tract infections and malaria. Ten percent of patients came with serious injuries due to accidents, six percent sought treatment for abdominal disorders and five percent had gynaecological or pregnancy problems. Another five percent suffered from cardiovascular diseases.

The emergency department was funded by a number of philanthropic foundations (Symphasis Foundation, Zurich, Switzerland; Hella Langer Foundation, Gräfelfing, Germany; Ernst Göhner Foundation, Zug, Switzerland). They covered the material expenses and my salary. The premises were built by the Swiss Agency for Development and Cooperation. All the salaries of emergency personnel are paid by the hospital or the state. A separate budget for the emergency unit is currently being created: all income from ultrasound examinations, ECG and interventions are paid separately into an emergency unit account. This money is used to pay for staff overtime, buy parts for equipment, maintain supplies and provide emergency medication to patients who have no money.

Last year, our project was awarded a prize by the Else-Kröner-Fresenius Foundation in Germany. The prize enabled us to buy three more ultrasound machines and some spare parts. It also financed three ultrasound courses and an emergency response course (including related payroll costs). Management of the emergency unit is in the hands of the Tanzanian colleagues. I work in the emergency team and am consulted on medical or organisational issues.

There are currently very few emergency departments in sub-Saharan Africa. The lack is especially great in rural areas. The Government of Tanzania wants to promote the establishment of more emergency facilities. Our unit is a model for other hospitals, showing that it is possible – through organisation and training and without much money – to create a functioning emergency department in rural Africa.

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Hospital serving a large rural area

St. Francis Referral Hospital in Ifakara provides hospital services for around one million people in the Kilombero, Ulanga and Malinyi districts in rural southwest Tanzania. The people live within a radius of 150 kilometres in a fertile alluvial plain. Rice is the main crop. Most of the people are farmers, but there are also herders, whose cattle find plenty to eat in the lush grasslands.

The hospital has 360 beds and specialised departments for surgery, internal medicine, obstetrics and gynaecology. There is also an eye clinic. Until our project was launched in November 2015, however, there was no emergency department. Emergency patients were seen in the hospital as outpatients. Most were transferred to the departments without a diagnosis or emergency treatment.

Patients initially had to buy all medication they needed from the pharmacy. That resulted in delays in both the diagnosis and treatment of many acute illnesses and injuries. As a result, many patients died before they were even treated. mr

The emergency room at St. Francis Referral Hospital in Ifakara.

Photo: Simone Utler/EKFS

Diabetes leads to other severe health problems – a patient in a Zimbabwean hospital.

Photo: Jeffrey Moyo

CHRONIC DISEASE

Costly diabetes drugs

Diabetes affects poor and rich people alike. The poor suffer in particular, however, especially in places where public health care is unreliable. Zimbabwe is an example.

By Jeffrey Moyo

Derick Samhindo is 45 years old and lives in Borrowdale Brooks, one of the posh suburbs of Harare, the Zimbabwean capital. He is a diabetes patient and has been in and out of hospital because of his chronic disease's secondary impacts. Thanks to his prosperity, he was so far mostly able to afford the medical treatment he needs.

He apparently has not adapted his diet to his medical condition, however. He looks overweight. Many patients fail to lose weight, and doctors admit that it requires a strong sense of personal discipline. It helps when patients can get healthy food they like. That of course, is a question of money.

West of the capital, in the poor neighbourhood of Kuwadzana extension, 52-year old Linet Mandizvidza is not so fortunate. She too is an overweight diabetes patient. However, the only meal she has known for years is sadza, the country's traditional staple food. It is a thick porridge made from boiled water mixed with mealie meal. It is not advisable for the diabetics in large amounts. Because of the long-lasting economic crisis, however, many people can no longer afford more expensive food.

Paying for the medical supplies Mandizvidza needs is a constant challenge. "There are few or no drugs for diabetic people like myself in public hospitals and I have to ensure I persuade well-to-do relatives to buy me the drugs so that I take them to help me live on in my fight against diabetes," she reports. She is now suffering from hypertension, which is a typical consequence of inadequately-treated diabetes.

Diabetes is a metabolic disorder, so diets matter very much. Diabetics' bodies do not process blood sugar well, so they should limit their consumption of sugar, carbohydrates and fruit, all of which increase blood sugar levels. Uncontrolled diabetes has severe impacts on the cardiovascular system, the eyes and other parts of the body. Consequences can be heart attacks, blindness or the amputation of limbs. The World Health Organization reckons that diabetes killed more people around the world in 2015 than HIV/AIDS, tuberculosis and malaria combined.

To some extent, diabetes results from a genetic predisposition, but it is also linked to a person's lifestyle and environmental factors. In the early stages, the disease can be controlled by sticking to a healthy diet and exercising regularly, and in later stages medication such as metformin pills are needed. At some point, patients must regularly inject insulin, the world market price of which is currently very high (see Max Klein in Tribune section of D+C/E+Z e-Paper 2020/01).

In the past, diabetes was considered a disease of the wealthy. As life expectancies have increased around the world and a greater share of people than ever are obese, diabetes has become more common. According to official data, more than one third of Zimbabwe's women and about 12 % of the men are overweight.

Elvis Norupiri, a medical practitioner in private practice in Zimbabwe, says: "Anyone can suffer from diabetes, either rich or poor. Mind you, Zimbabweans eat lots of carbohydrates and these contribute to diabetes."

TEN PERCENT OF THE PEOPLE

The Zimbabwe Diabetic Association (ZDA) estimates that 1.4 million Zimbabweans or about 10 % of the people have diabetes. Government statistics indicate that rate too. Because many cases are never diagnosed, it is impossible to tell the true number. Those who lack access to health care may never learn they are affected by this disease.

ZDA is a non-profit organisation that represents – and supports – the growing number of people with diabetes, those at risk and their care givers. ZDA points out that a single diabetic patient may easily require a monthly $300 or more for medication and related costs. In Zimbabwe, that is a lot of money.

Things are particularly bad for those who need insulin. However, drugs like metformin and glibenclamide are becoming ever more expensive too. Consumer price inflation amounted to approximately 300 % last year, according to the International Monetary Fund, so people's purchasing power has been declining fast.

Making matters worse, Zimbabwe's government recently approved an increase in public hospital fees. An adult must now pay the equivalent of about $15 for a mere consultation. The public health system, moreover, is largely considered to be dysfunctional.

Not everything can be blamed on the economy and governance, however. Jonson Bhebhe, a Harare-based diabetes expert, finds it upsetting that "people have shelved nutritional foods and become obstinate in taking foods which are dangerous to their health". He argues that people should stick to healthier diets. In his eyes, that need not be unaffordable.

Bhebhe links Zimbabwe's increased diabetes prevalence to rapid urbanisation, industrialisation and changing diets. He also bemoans that "sedentary lifestyles" have led to less physical activity. Other chronic diseases are spreading in developing countries too (see focus section in D+C/E+Z e-Paper 2018/03) The consequences are depressing. According to Bhebhe, some 17,000 Zimbabweans died because they were diabetics in 2014 alone.

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TUBERCULOSIS

Never disrupt treatment

In the past three decades, progress in the fight against tuberculosis (TB) has unfortunately slowed down. The reasons include the development of drug-resistant strains as well as the HIV/AIDS crisis. To make the world TB free, funding must increase dramatically.

By Roli Mahajan

Today, TB is one of the top ten causes of death around the globe. It kills more people than any other disease caused by one particular infectious agent. In 2018, globally 1.5 million people died because of TB, reckons the World Health Organization (WHO), while almost 10 million fell ill with it. An estimated one third of the new cases remain unknown to health professionals, so many patients do not get proper treatment.

TB is transmitted primarily when an infected person coughs, sneezes or talks, letting out droplets containing Mycobacterium tuberculosis. It affects both the rich and poor, but the impact is obviously far worse when people cannot afford medical services.

When first discovered in 1882, TB caused one in seven deaths in Europe and America. However, due to medical progress in the past century, a TB-free world seemed to be within reach. Yet progress slowed down considerably in the 1990s.

One reason was HIV/AIDS. People with weakened immune systems are most susceptible to all kinds of infectious diseases, including TB. According to the WHO's Global Tuberculosis Report 2019, TB caused 251,000 deaths among HIV positive people in 2018. The good news is that there has been considerable progress in stemming the spread of HIV/AIDS, and accordingly, the number of TB fatalities among AIDS patients in 2018 was actually 60 % below the respective figure for the year 2000.

The greater problem, however, is the evolution of antibiotic-resistant TB strains. To a large extent, this problem is a result of human negligence and ignorance. Patients normally need a six to nine month course of antibiotics to cure the disease. If treatment is discontinued earlier, drug-resistant pathogens develop. Poor people who do not get free medication have a tendency of stopping the intake of antibiotics once TB symptoms subside. As the course of the medicine is not complete, they do not realise that the disease has not been cured completely.

It adds to the problem that the regulation of pharmaceuticals is inadequate and poorly enforced in many developing countries and emerging markets. All too often, potent antibiotics are sold indiscriminately. As a result, TB bacteria develop resistance even against comparatively new drugs. Antibiotics application in animal husbandry or the improper treatment of wastewater by pharmaceutical companies can also facilitate the emergence of antibiotic resistance.

There are now several different antibiotic-resistant TB strains. The most danger-

Examining a patient in Assam.

ous ones resist more than one drug. Experts speak of "multidrug resistance" (MDR). According to the WHO, about 5% of the new TB cases diagnosed in 2018 could not be treated with conventional TB medication.

EPICENTRE IS INDIA

Today, low- and middle-income countries (LMICs) bear the brunt of TB. To a large extent, their local-level capacities are weak and lack the resources they would need to tackle this disease. Five countries accounted for more than half of the global disease burden: India (27%), followed by China (9%), Indonesia (8%), the Philippines (6%) and Pakistan (6%). The world region with the most cases was South East Asia (44%). Africa accounted for 24%.

The disease kills about 450,000 Indians annually and costs government agencies the equivalent of about $580 million. According to WHO statistics, there were 2.7 million new tuberculosis cases in India 2018, of which almost 2 million were registered and an astounding 130,000 were antibiotic resistant. These numbers make India the epicentre of TB.

So why is India finding it so difficult to control TB? Experts say that the long-standing strategy to control TB was based on a faulty proposition. The idea is that people who have TB will be sick; that sick people will seek and get medical care; that they will be diagnosed and given proper treatment; and that they will be cured in six months. In real life, none of these things can be taken for granted. India needs to shore up its act.

Indeed, Prime Minister Narendra Modi has promised to end TB in India by 2025. Strategies have been adopted to screen vulnerable communities and detect TB patients. Moreover, efforts are being made to test patients for drug-resistant strains, and faster diagnosis methods are being introduced. Almost 190 million people were screened in 2018, according to the government, and an additional 47,000 TB cases were diagnosed this way. India quadrupled its domestic TB funding from 2016 to 2019, according to WHO data. These are steps in the right direction, but much more needs to happen to eradicate the disease.

REVOLUTIONARY VACCINATION

At a global conference on lung health in the Indian city of Hyderabad, an international team of researchers announced a "revolutionary" new tuberculosis treatment in 2019. A vaccination would thus provide long-term protection against the disease. Made from bacteria proteins that trigger an immune response, it has proven effective and seems to enable a person's immune system to ward off TB.

The vaccine has yet to be licenced and will not be available on the market before some more years. However, initial clinical trials on adults in South Africa, Kenya and Zambia have proved successful. International experts agree that this vaccine may become a game changer.

In 2018, the UN set the goal of ending TB by 2030 as part of the SDG agenda (Sustainable Development Goals). It is obviously essential to mobilise resources for this purpose. Relying on their own resources, members of the BRICS group (Brazil, Russia, India, China and South Africa) accounted for about half of the $7 billion made available for treatment globally in 2019.

By contrast, international donor funding amounted to a mere $900 million, according to the WHO, whereas it should afford $2.7 billion. The multilateral organisation has identified serious funding gaps: its statistics show that $10 billion are needed for curative purposes ($3 billion more than currently afforded) and another $2 billion are needed for research and development ($1.3 billion more than currently afforded). The international non-governmental organisation Doctors without Borders (Médecins sans Frontières – MsF) has similarly pointed out that the donor community must do more (see article by Florian Gaisrucker on p. 33 in this e-Paper).

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Photo: Nath/picture-alliance/AP Photo

SANITATION

"A supportive environment"

Appropriate hygiene can prevent many infectious diseases. Accordingly, the acronym WASH (for water, sanitation and hygiene) has become a development buzzword in recent decades. Considerable progress has been made in many countries, but much remains to be done. Ella Naliponguit of the Department of Education (DepEd) in the Philippines told Linda Engel about WASH in Schools (WinS), a national programme she has been spearheading since 2007.

Ella Naliponguit interviewed by Linda Engel

Many schools worldwide suffer from insufficient funding. Why should they focus on water sanitation and hygiene (WASH) in schools nonetheless?
Well, remember children spend most of their day in schools. So, schools have to ensure that they offer a supportive environment where children not only learn, but where their basic needs are met.

Please describe some of the milestones for WinS in the Philippines?
Basically, we had to start from scratch. Between 2007 and 2010 the government built a lot of classrooms, but was not able to build toilets for the growing number of learners. While waiting for government response, schools welcomed the initiative of parents to build basic, but fully functional in-classroom toilets that their children can use. This initiative may be acceptable for younger kids, but gender-segregated toilets are recommended once kids reach puberty.

WASH in schools is not only about infrastructure, but also about teaching children hygiene habits. What do you do?
We wanted to improve tooth-brushing habits. In a study from 2007 we found out that nine out of ten children have dental caries in the Philippines.

Second, to this day we still have open defecation. We thought the least we had to do was to enable children to learn about the importance of hygiene and sanitation at school. Thus a programme was started that enables children to practice hand washing at critical times, brush their teeth in school and be given deworming treatment twice a year. The hygiene activities are a drill that young children have to do while in class along with health education. Deworming is a regular programme were the Department of Health and DepEd work hand in hand.

That sounds very ambitious. What challenges do you face?
The challenge we face is that the activities require hygiene supplies and water. Both are expensive. We also want to improve the cleanliness and maintenance of the toilets by holding parents, school officials and the children responsible.

How do you ensure the schools do what you tell them?
In 2015 we drafted a comprehensive water and sanitation policy. It is very good, and to make sure it is implemented, we introduced a monitoring tool according to the "Three Star Approach". We use a questionnaire to survey all schools, and they must rate their own performance with one, two or three stars. This kind of self-assessment makes the school principal accountable. In our archipelagic country, the principal is the person who best understands the locally specific needs.

What are the greatest remaining challenges?
Our target is that 100 % of schools implement measures to meet WinS indicators. We still haven't met that target. Additionally, we are supporting actions to address menstrual hygiene and health management. Behaviour change is starting to develop but not as fast as we would like. Thus we feel it is prudent to involve the local communities rather than to just rely on action in schools. Moreover, though Philippines is a disaster prone country, we have not looked very closely into WINS in emergencies.

What are you doing?
The Philippines are very much affected by typhoons. Currently, our department is preparing guidelines on "WASH in schools in emergencies". We have disaster risk reduction policies in place, like earthquake drills in schools. But it is not clear what WinS interventions should be put in place after a disaster. In emergencies, schools are used as evacuation centres. Therefore, it is especially important to restart water services as fast as possible and to repair toilets. For children, it is important after a disaster to go back to a normal life. It's a big part of their healing process.

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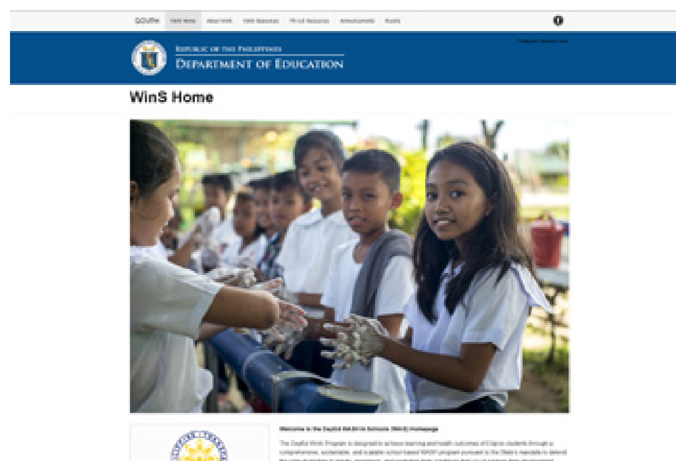

The "WASH in Schools" website.

Screenshot: https://wins.deped.gov.ph

GLOBAL CHALLENGE

Wake-up call to donors

The international non-governmental organisation Médecins Sans Frontières (MSF – Doctors without Borders) bemoans that funding is declining for programmes to fight HIV/AIDS and tuberculosis (TB). In a recent report, the charitable agency spells out the negative impacts. Progress already made in limiting the spread of these diseases is being undermined.

By Florian Gaisrucker

The study assesses nine developing countries. According to MSF, many sub-Saharan countries have HIV/AIDS infection rates of up to 20 %. The key to preventing the spread of a disease and providing effective therapies is to identify infections fast. In 2017, there were about 10 million new TB patients, MSF reports, 9 % of whom were HIV-positive. In more than 500,000 cases, they suffered from antibiotic-resistant strains.

MSF warns that funding for HIV/AIDS and TV programmes has fallen behind the need. In 2016, it was determined in the context of the WHO (World Health Organization) that an annual $ 26 billion at least would be needed until 2020. In 2018, however, only $ 19 billion were made available, and that was $1 billion less than in 2017.

The two most important donor institutions in the fight against HIV/AIDS and TB are the Global Fund and PEPFAR. The Global Fund relies on public and private funding; it was established to fight the two diseases as well as malaria. PEPFAR (President´s Emergency Plan For Aids Relief) is a US initiative. According to the MSF publication, both have reduced their spending.

As MSF reports, both institutions want recipient countries to increase their health spending, including for procuring medication and paying staff. However, MSF reckons that annual investments worth $ 370 billion are needed to provide universal healthcare internationally. The authors insist that countries with weak economies and low tax revenues are overburdened already.

Moreover, some countries – including the Central African Republic or the Democratic Republic of the Congo, for example – are said to be struggling with multiple humanitarian, geopolitical and economic challenges. They include:

- refugees spreading diseases,
- failed harvests due to droughts or flooding and
- corruption.

Less international funding for health programmes is likely to undermine the progress made in the fight against HIV/AIDS and TB, the MSF publication argues. For example, the treatment of individual TB patients may be interrupted or discontinued entirely, which makes the emergence of drug-resistant strains more probable. Another downside is that people's faith in doctors and professional healthcare is being eroded.

In some countries, infection ratios are rising again, according to MSF. The agency warns that the international community is far from getting a grip on the two diseases. It appreciates success in some countries, but points out that they do not suffice and that things are worse in other places. Among other things, the MSF experts demand that

- TB treatment must always continue and not fall behind contemporary standards,
- some emergency funding must be established to avoid bottlenecks, and
- the grassroots initiatives of local communities must get more support.

MSF wants the World Bank and other donor institutions to establish new funding instruments and improve conditions, so private-sector companies will invest in public health. They could, for instance, build and run hospitals. Governments of developing countries should be put in charge of oversight and guarantee that funds are used prudently. The publication also suggests that relevant agencies should draft strategies of their own.

The humanitarian organisation does not oppose the shift from international to national funding as a matter of principle. Its point is that the impacts of that shift must be controlled so neither the quality of healthcare systems nor the quantity of their services will suffer. MSF wants international donors, including the Global Fund and PEPFAR, to support developing countries in ways that prevent avoidable medical hardships.

Hospitalised tuberculosis patient in Cameroon.

LINK

Médecins Sans Frontières, 2019: Burden sharing or burden shifting? How the HIV/TB response is being derailed.

https://www.msf.org/burden-sharing-or-burden-shifting

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Photo: Heine/Lineair

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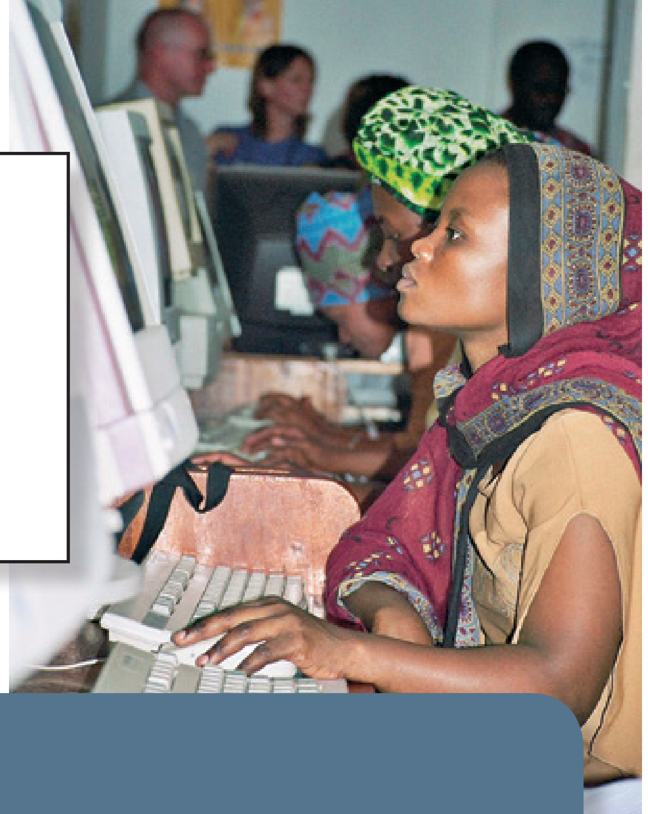

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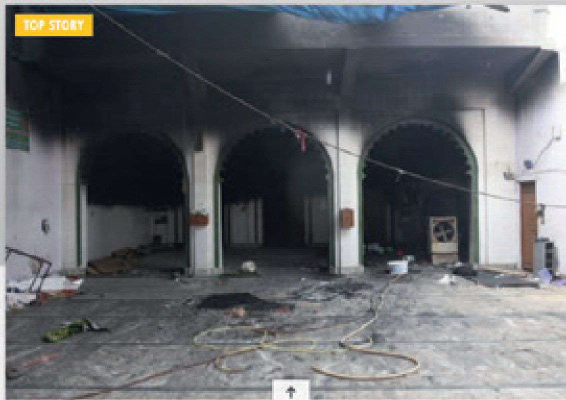

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